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Professional Organizations and Public Personnel*

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SOCIAL services under public auspices have been developing so rapidly during the last few years that it has become a serious question whether the professional organizations can secure and maintain a position of leadership in the administration of these activities. It has been a common practice in the past for professional groups merely to carp at the kind of work being done by official bodies; too often we have stood aside and gazed with contempt at these organizations because they did not live up to our standards. We have somehow felt that, without any assistance on our part, public bodies should have attained the lofty peaks of perfection to which we think we have climbed. As a matter of fact, the standards of public social services will go forward only if the professional organizations assume the responsibility for assisting public administrators to understand and to accept their standards, and professional movements will have vitality only if they have meaning in public administration.

My purpose is to discuss some suggestions of how, in my opinion, the professional organization can best play a part in improving public personnel practices. I have naturally approached this from the standpoint of social work, since that is my field, but I think that the public health nursing movement faces similar situations and similar problems. In this discussion I should like to consider, first, possibilities for the national professional organization's participation in improving personnel; second, the part which the professional in the public administrative job can play; and third, the responsibility which the private or voluntary agencies have in the scheme of things.

The national professional organization should be looked to by public administrators and by members of the profession as the source of light and information on the standards required for various types and grades of positions within the profession. The first thing the professional organization must do, therefore, is to have a standards or personnel

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committee whose function it is to set up training and experience qualifications for the span of positions which appear in large public organizations. These standards, of course, must be established in terms of training and experience possibilities which exist or which can be put in motion.

Having set up standards for various types of positions and organizations, this national personnel committee is then in a position to offer advisory service to local groups in the profession. Consequently every state or local branch of the professional organization should be interested in the subject of personnel administration and the national committee should both stimulate the organization of such committees and furnish them with material with which they can work. Of necessity the national standards must be adjusted to state and local conditions and this is the particular business of these subsidiary committees.

I find there is a tendency for some professional groups to feel that they alone are interested in improving personnel methods. Recently I had a long argument with a friend of mine who felt that his own national committee on personnel should attempt a nation-wide crusade for the establishment of civil service commissions in states and municipalities. Such a procedure would be absurd because we are all aware that not only professional organizations, but groups interested in public administration as such, have been giving many years of time and effort to the promotion of better public personnel practice. I would urge, then, that your national organization be in touch with efforts of other professional groups to improve public administration. We will be able to secure better standards of personnel practice in cities, counties, and states, only if we combine our efforts for good administration.

The national organization is naturally interested in professional training and should be stimulating the training schools to provide the kind of curriculum which the field needs. I know that in social work we have been so busy developing courses in techniques that we have neglected to see where these techniques fit into the community or fit into the administration of services to the community. We have been training experts for a vacuum. Administration must be a part of the training for public health work or for social work and I feel that any one who is to assume the responsibility of a supervisor or executive in either an official or voluntary agency must know good principles of personnel practice. The national personnel committee should see that personnel administration is included in all approved training programs.

THE PROFESSIONAL IN THE PUBLIC JOB

After all, the people who have really made strides in securing good standards for professional personnel have been those pioneers who have risen to positions of public administrative responsibility. The professional person who is responsible for staff selection occupies the most strategic place from which to work for better standards. Professional people who get into administrative jobs and are not alert to their responsibilities in the field of personnel do irrevocable harm to the development of good standards. In sketching some of the contributions which the professional person in a public administration job can make to the development of public personnel practice, I shall mention some things which may seem elemental. I think, nevertheless, they need to be repeated just because they do seem so obvious.

Primarily, the person in a public job who is selecting his staff members must know quite specifically what he wants. That sounds so simple that you may think it ridiculous of me to mention it, but as a matter of fact, I find a common weakness of public administrators is that they can not define their personnel requirements. The worst personnel job I ever had to handle was an eighteen months' search to fill a job where the administrator above me could not say specifically what he wanted. I trotted out candidate after candidate, guessing at the requirements, but it was a wasteful procedure. I could not find satisfactory candidates because the ad-

ministrator could not sit down and say, "This is the kind of man I want." One's requirements for personnel must be objective and specific. They must be set up in terms of a specified type of training, clearly defined experience, and precisely stated aptitudes.

When the administrator knows what he wants he then has the job of getting these requirements across to the personnel officer or the personnel service of his administration. The more clear-cut his own delineation of his requirements, the more success he will have in getting the approval and acceptance of the appointing body. Incidentally, whether one is protected by a civil service system or not, the best guard against outside manipulation of appointments comes from an exact definition of requirements expected of applicants for jobs. I have known public organizations with no civil service protection at all which have withstood a great amount of political pressure by consistently saying, "The people we have to have for our services must meet our stated qualifications."

I should like to speak of certain procedures which are helpful under civil service. As suggested above, the administrator should acquaint the civil service commission with the kind of people needed in the organization. The professional person must realize that he must take the initiative in presenting his needs to the commission, since that body has the responsibility for conducting examinations for all of the diversified positions required by the services of government. I recently looked over the complete classification schedule of a state to find out what social work positions were included. I was amazed at the great assortment of professions and jobs included in this volume, and I was also chastened to realize what a small percentage of the volume was given to the field of public welfare. I recommend going through a list of jobs under the civil service commission which operates in your area, in order to be humble about your own profession. Such a review will convince you that you must interpret the needs and requirements of your field. If you assume an interpretive rather than a demanding attitude, you will find that the ordinary civil service officer is exceedingly anxious and willing to coöperate with you.

An interesting example of united effort by professional groups on civil service examinations is found in the nursing field under the United States Civil Service Commission. The U. S. Public Health Service, the Veterans Administration, and the Indian Service are jointly served by a blanket set of examinations, with standards mutually agreed upon by these federal departments and the Civil Service Commission.

Another helpful coöperative device is the examining committee. Frequently a civil service commission will be glad to invite outstanding representatives of a profession to participate in rating civil service examination papers. The committee under such circumstances acts for the civil service commission, usually with one staff member of the commission on the committee. This gives the profession an opportunity for interpretation of standards. Often the professional people in administrative departments are called upon to assist informally in the actual rating of examinations, sharing with the commission the responsibility for such rating.

There are several fairly new developments of procedure for securing good personnel where no civil service commission is in existence. The social workers in California have been working on a registration plan which is borrowed from the experience of the nursing profession. This at least provides a means for establishing a minimum standard for appointment to public jobs. The regulation would say, for example, that any person to be eligible to stand examination for a certain position must be a registered social worker, or a registered public health nurse. I think there is considerable promise also in the so-called certification plan, which of course has been used extensively in the field of education. In Alabama, for example, the State Child Welfare law requires that the State Child Welfare Department must certify all county child welfare workers.

It has become a habit in our private agencies to view with disdain the personnel practices and political muddles of the public organizations. I must say that by-and-large, the worst personnel practices I have observed have been in private agencies. Very little in public organizations can compare with the petty board member intrigues and staff politics which frequently exist in private organizations. These usually are under the surface, because the private agency is not so frequently exposed to the wholesome penetration of the light of public opinion.

I will grant that the private agencies have an opportunity to set the pace for good personnel administration in our fields of work, but to do so they must begin by adopting the fundamentals of sound personnel work. There should be carefully worked out standards of selection of staff, promotion, and of working conditions. A good private agency can do much to help a public agency put its standards across by itself showing the advantage in terms of good performance both of high grade personnel and of objective, judicious personnel procedure

Some of you may feel that it is rather futile to talk about standards of personnel in these days of salary cuts, staff eliminations, and tremendous pressure for jobs. Granting all these difficulties, I still do not regard the present situation as even temporarily discouraging. In fact, I think there are several very promising tendencies to be noted. Among these is the intensification of interest in government as such, which has naturally resulted from the tremendous amount of governmental activity during the last few years. Also, whether you like the concentration of authority in Washington or not, it seems to me you must grant there will be a number of advantages gained in the field of personnel from the present federal activity. The United States Employment Service, for example, is setting up an interesting procedure in personnel requirements which will be exacted of a state participating in the federal-state employment program. Many of the emergency agencies which reach down into the states have set up specific requirements for positions to represent that activity in the local areas. We also have an unusually able Federal Civil Service Commission, which is already being heard from and which, I predict, will make a permanent mark on public personnel policies.

In view of the increasing number of social services under public auspices, it is timely to have Mr. Lansdale's thoughtful discussion above of the place and influence of the professional organization. In our own field, the "national professional organization" to which he refers is naturally the National Organization for Public Health Nursing and we are proud to have completed and circulated the standard qualifications for positions in public health nursing, the objectives of our services and to announce again the recent formation of a new N.O.P.H.N. committee to study personnel practices in public agencies. The personnel of this new committee is:

Grace Anderson, *Chairman*, East Harlem Nursing & Health Service, New York
Mary S. Evans, State Department of Health, Harrisburg, Pa.
Amelia Grant, New York City Department of Health
Elinor Gregg, United States Indian Bureau
Mrs. Violet H. Hodgson, Westchester Co. (New York) Department of Health
Mary A. Hulsizer, Newark (New Jersey) Public Schools
Pearl McIver, United States Public Health Service
Katharine Pierce, John Hancock Mutual Life Insurance Co.
Lillian Quinn, Joint Vocational Service
Mildred Sanderson, St. Louis Department of Health
Mary Swanson, New York State Department of Education
Agnes G. Talcott, Los Angeles Health Department
Cora Templeton, Cleveland Department of Health
Cornelia Van Kooy, Wisconsin State Board of Health
Marguerite A. Wales, Henry Street Visiting Nurse Service
Mrs. Anna J. Miller, Statistician, N.O.P.H.N.
Anna L. Tittman, Joint Vocational Service
Katharine Tucker, General Director, N.O.P.H.N.

The Need for a More Adequate Program of Maternal Care*

By FRANCES C. ROTHERT, M.D.
United States Children's Bureau

YOU remember the White House Conference on Child Health and Protection, here in Washington four years ago, and those figures on what proportion of the children in certain communities had been immunized against diphtheria, had had health examinations, and so on. Some of you must have helped gather those figures. The reactions to those figures were interesting, as well as the figures themselves. Some of the pediatricians, particularly the teachers, were astounded, and a trifle discouraged. "What," they cried, "all these years we have been teaching the value of immunization and still only one-fifth of the preschool children protected against diphtheria?" Some of us public health workers were surprised, too, but what we thought was this: "Really, one-fifth immunized already? How splendid! We have been working for such a short time, and under such difficulties! Now we must go home and get to work harder than ever on the rest of them. And how our diphtheria rate will drop!"

Somewhat similar attitudes are being taken toward the much more complex problems of maternal care, and the light that recent studies of maternal mortality throw on them. The members of the Children's Bureau advisory committee of obstetricians were horrified when they saw the figures on prenatal care from the maternal mortality study in 15 States. "What, of all these 7,500 women who died in these States during these years, only 42 had, as far as we know, adequate prenatal supervision? And some of those had quite poor treatment!"

Some of us, on the other hand, were quite cheered up by these very same figures. The women in the study were only those women who died. Among the total of a million and a quarter women who had babies in those 15 States there must have been thousands who had had adequate prenatal care, and only 42 of them were among the 7,500 who died! And even some of those 42 could probably have been saved if they had had better treatment—better delivery care.

THE PLAN OF THE STUDY

The 15 States included in the Children's Bureau study, on account of their location, the composition of their population as regards color, and their distribution among urban and rural, are quite typical of the United States as a whole. The rural and western women were better represented than the urban East. But this has been more than supplemented by the Academy of Medicine Study in New York City.

The maternal mortality rate in the States of the Children's Bureau study was slightly lower than in the Birth Registration Area—conditions as regards maternal mortality were evidently a little better in the States studied than in the United States as a whole.

Each of the 7,537 deaths assigned by the Bureau of the Census to the vital statistics heading "The puerperal state" was studied by interviews with the attending physician or physicians or midwives as soon as possible after the death, and the hospital record, if any, was consulted. The Study was always done at the invitation of the State medical society. Physicians on the staff of the State board of health did most of the interviewing in six States and Children's Bureau physicians in nine States. All kept in closest contact with the Children's Bureau throughout, and all statis-

*Paper read before the N.O.P.H.N., general session, Biennial Convention, Washington, D. C., April 26, 1934.

tical work was done by the Children's Bureau.

The Bureau had at all times the assistance of its obstetric advisory committee—Dr. Robert L. DeNormandie of Boston, Dr. Fred L. Adair of Minneapolis, now of Chicago, Dr. Rudolph Holmes of Chicago, Dr. James R. McCord of Atlanta, Dr. Alice Pickett of Louisville, Dr. Otto H. Schwartz of St. Louis, Dr. C. Jeff Miller of New Orleans, Dr. Frank W. Lynch of San Francisco, and, until his death, Dr. Ralph W. Lobenstine of New York. Dr. DeNormandie outlined the plan for the study. The committee was in particularly close communication throughout the analysis of the material and the writing of the report, for which, in addition, they furnished the comments and recommendations.

The findings were first reported to the State medical society and to the State board of health of each of the individual States studied. In analyzing the material the deaths were not grouped as preventable or not preventable. The conditions surrounding the deaths were presented as objectively as possible, —with the care and treatment the patients had. In many cases this care was obviously far from adequate.

DANGER OF ABORTIONS

Of fundamental importance was the finding that one-third of the women died before they had reached the last trimester of pregnancy, or before the child was viable. The proportion varied between urban and rural and white and colored and in the different States from less than one-fifth to nearly half. These early terminations constitute a problem rather different from what is usually meant by "maternal care." So many followed induced abortions or neglected spontaneous abortions that the advisory committee has emphasized that women *must* be taught that abortions are exceedingly dangerous. A public health nurse has many opportunities to do this.

To prevent deaths following early terminations of pregnancy the patient must obviously be contacted earlier still and so the community must be taught that care should begin as soon as pregnancy is determined.

These figures also emphasize the caution that must be used in interpreting statistical evaluations. The records of an organization giving maternity care, or of the obstetrical department of a hospital, seldom include abortions and ectopic gestation cases. If the maternal mortality rate of such an organization is to be compared fairly with the maternal mortality rate of a city or state, the city or state rate should usually be reduced by about one-third to take out those early terminations and to make the rates at least roughly comparable.

PRENATAL CARE ALMOST TOTALLY INADEQUATE

I have already mentioned the very small number of women who had had adequate prenatal care. In classifying the prenatal care received we omitted from consideration the women who had had induced abortions or whose pregnancy terminated before the third month. There were 1,154 women in this group. For another 590 women no report on prenatal care was available. Few of them are likely to have had any care. But even of the remaining 5,636 women, less than one percent had adequate care according to standards that had previously been drawn up by the committee. Twelve percent more had what was, on the whole, good care, beginning not later than the fifth month. Nine percent had fair care, beginning not later than the seventh month. Twenty-four percent had poor care, little better than none, and fifty-four percent had never been seen by a physician before the onset of labor or the acute emergency.

This surely points to the need for a more adequate program of maternal care! Considering only those women who might have been expected to have had prenatal care, more than half had no prenatal care, a fourth had poor care, grossly inadequate; an eighth had reasonably good care. And this refers merely to the ordinary standard examinations,—regular visits with urinalysis and blood pressure examinations, pel-

vic measurements for primiparae and for multiparae having a previous difficult delivery. It does not necessarily imply good treatment.

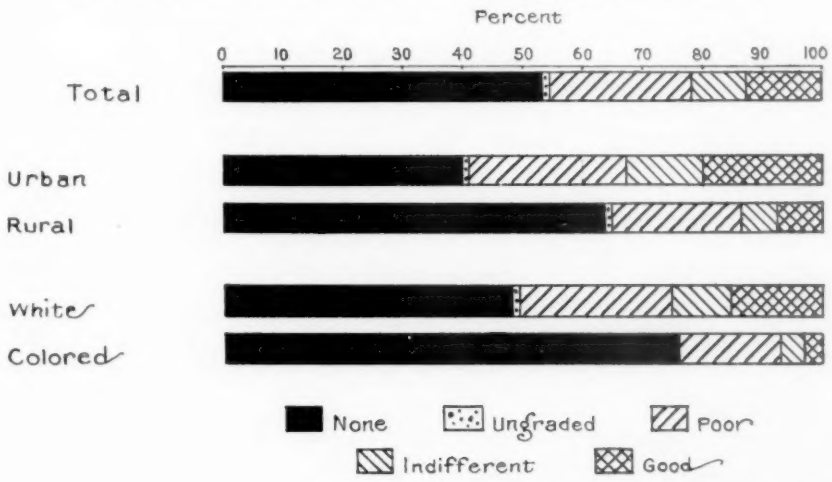
The women who died in rural areas, which includes towns of less than 10,000 inhabitants as well as the open country, had received much less prenatal care than those who died in the cities. Even in the cities there was room for considerable improvement, as forty percent had had no care, twenty-six percent poor care. Twenty percent had good care. This may be compared with thirty-eight percent adequate care, sixty-one percent inadequate or no care, in the New York city figures.

In the rural areas twenty-two percent had poor care and sixty-four percent had none—a total of eighty-eight percent with grossly inadequate or no care. Only eight percent had good care.

The white women, as might be expected, had had more prenatal care than the colored women. Even so, seventy-three percent of the white women who died had poor care or none at all. But of the colored women ninety-three percent had poor care or none, and for rural colored women this figure was ninety-seven percent. When we consider the enormous maternal mortality rate of colored women, nearly twice that of white women, we hardly need say "Here is work to do!"

But when we are asked "What have you been doing all these years?" we must remember, as I have said before, that these figures I have just given you are women who died. Of the ones who lived we have no record. Most of the women that you urged, pushed, and dragged into getting prenatal care lived. These figures, too, are for 1927 and 1928. Education of women has continued since them. But whether the services to pregnant women are as good now as in the happy days of 1927 and 1928 is a question that each has to answer for her own community.

TABLE 1. PRENATAL CARE AMONG WOMEN DYING FROM PUERPERAL CAUSES



Courtesy of the U. S. Children's Bureau

Of these women who died, the ones least likely to receive prenatal care were the primiparae and the mothers of many children. Besides being the hardest to reach, these women are the ones to whom childbirth is most dangerous. There is still much to be done with these groups.

DELIVERY CARE FREQUENTLY DEPENDENT ON GOOD PRENATAL CARE

Why am I talking so much about prenatal care? The best prenatal care is of no avail unless it is followed by good delivery care and good postpartum care. Continuous, adequate prenatal, delivery,

and postpartum care is what is needed.

In the first place, good delivery care is in many cases impossible without good prenatal care. Let us look at the causes of the deaths of these women. If we consider only the 5,000 (4,965) women who reached the last third of pregnancy—that is where delivery care, as we usually think of it, comes in—we find that sepsis and toxemia each accounted for thirty-one percent of the deaths, hemorrhage for sixteen percent, accidents of pregnancy and labor sixteen percent, embolism six percent.

While toxemia cannot be controlled by prenatal care alone, its control is impossible without prenatal care. In this connection it is of interest to note that of the 1,900 women who died of puerperal albuminuria and convulsions, of those whose condition when they were first seen by a physician was known, nearly a third had had convulsions or were in coma before they had any medical care. Only a fifth were in good condition. Among the colored women, even more of whom die from puerperal albuminuria and convulsions in the last trimester than from sepsis, fifty-six percent were in convulsions or coma and thirty percent more in poor condition when first seen. Think what a different story might have been told if a public health nurse had seen these patients when they had their first symptoms!

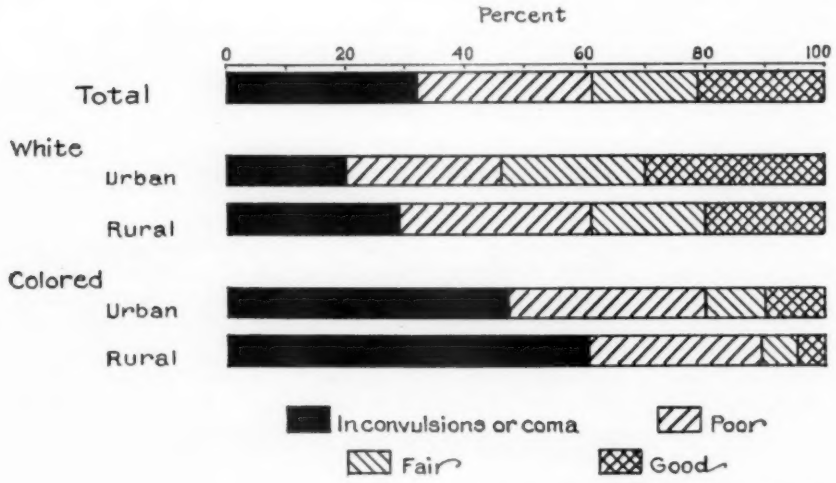
The prevention of sepsis through prenatal care is less direct. But the emergency operation certainly carries a greater risk of sepsis than the planned operative delivery. For forty-three percent of the women in this study who died following operations no plan was possible because they were not seen by a physician before labor or the acute emergency,—in other words they had no prenatal care. Remember, too, that toxemia and hemorrhage render women an easy prey to infection.

Hemorrhage—the rôle of prenatal care here is to teach women that any bleeding during pregnancy is a danger signal. Of the 408 women who had placenta praevia and died, 236—more than half—were known to have had a warning hemorrhage. In most of these cases the warning had been disregarded.

Accidents of labor—here again unplanned, emergency operations take their toll.

Another reason why I have stressed prenatal care this morning is because here is where you, as public health

TABLE 2. CONDITION WHEN FIRST SEEN BY PHYSICIAN OF WOMEN WHO DIED FROM PUERPERAL ALBUMINURIA AND CONVULSIONS



Courtesy of the U. S. Children's Bureau

nurses, can at present do your most effective work in reducing maternal mortality. If you can educate all women to regard having good prenatal care as much a part of the routine of having a baby as a layette, so much the better,—but many lives are saved because, as one mother said to me the other day, "The nurse, she keep after me so, I have to go to the doctor and do what he say to keep her quiet!"

I cannot now do more than touch on the question of what is good prenatal nursing. The most important thing, of course, is the very close coöperation that is necessary between the nurse and the physician, and the close correlation between prenatal care and delivery care. After all, what can be done by prenatal care? Systematic diseases can be discovered and treated; focal infections can be discovered and eradicated; toxemias can be detected early; the mother's health habits, particularly as regards diet and rest can be maintained or improved; her resistance can be built up, the delivery planned; she can be put in the best possible shape for delivery. Obviously a safe delivery is the whole aim of prenatal care as far as the mother is concerned. And for the baby also prenatal care is frequently a question of life or death, as you all know.

A tactful nurse—in addition to leading a mother to prenatal care—may in some cases affect the mother's whole attitude toward her pregnancy and delivery. Many unnecessary operations are due to the insistence of the mother on a rapid, painless delivery. A nurse can sometimes see this coming and teach her that her physician is the proper judge of her type of delivery. In the stress of pregnancy, a woman sometimes forgets for a little while that, of all achievements, *hers*—the bringing of a new person into the world—is the most worthwhile; and that it is to be expected that this would demand effort, and self-sacrifice, and perhaps pain. Being human she sometimes forgets a little the glory that is to be hers, and here too, a tactful nurse can help her.

Of course, prenatal care is only the beginning. Good delivery care is indispensable. The importance of good postpartum care is only beginning to have the attention that it deserves, for it is important not only for the immediate safety of the mother, but for her health for many years; among other things in the prevention of cancer of the cervix. Getting the mother to go back to the doctor for a postpartum examination and treatment is frequently a nursing problem. Adequate, continuous medical and nursing care for every woman during pregnancy, at delivery, and throughout the postpartum period is not a far away ideal; it is a pressing, immediate need. The community has a definite responsibility to provide this care. Just how this care is to be provided must of necessity vary in different communities. Dr. Kosmak in his masterly discussion of this problem has just given us great help here. The public health nurse has one of the leading rôles to play in providing adequate maternity care for all women—not only because she has a large part of the work to do herself, but because she must help to mold public opinion, to arouse the community conscience, so that her work and the work of the others associated with her in this problem is not only *possible*, but always improving and developing toward new goals.

Public Health Nursing in Peiping, China

By ANNE McCABE, R.N.

Miss McCabe spent several years in China as instructor of nursing in relation to public health at the Peiping Union Medical College and as Chief of the Division of Public Health Visiting at the First Health Station in Peiping. She is now a supervisor in the Instructive Visiting Nurse Society, Washington, D. C.

IN order to appreciate what public health nurses are trying to do in China it is necessary to relate briefly the customs of the Chinese and their environmental conditions in Peiping, where public health nursing has developed as part of the first organized community health demonstration in China.

The Metropolitan Police Department of the Municipality of Peiping, in cooperation with the Department of Hygiene of the Peiping Union Medical College, planned the Health Station in 1925, to demonstrate curative and preventive medicine in a single administrative unit. This demonstration was limited to approximately 50,000 of Peiping's 1,000,000 population and the government assigned an old Buddhist temple in the First Inner Ward as headquarters for the clinics and administrative offices.

The Chinese as a race are conservative and this is particularly true of the northern Chinese, who have had little or no contact with the West, and who cling tenaciously to the traditions and folk-lore of their ancestors. The population of Peiping is classified as rich, average poor, and very poor; and about 83 percent have never been to school.

LIVING CONDITIONS

While it is impossible to make generalized statements about any community, the majority of the people whom the Health Station wishes to reach fall into the very poor, uneducated, group whose home life has changed little from that of the forefathers. The family is still the nucleus of Chinese society with the mother-in-law as supreme authority over her sons and their families in the home. The houses are built of sun-baked, grey brick, one story high, with dirt or stone floors. They open off a courtyard and the number of chien (rooms) and courtyards to a family are in proportion to the family income. The very poor usually have only one chien, which serves as kitchen and sleeping room. Small portable stoves in which coal balls are burned are used for cooking and heating. These balls are made of mud rolled in coal dust and dried in the sun.

Water is obtained from the numerous wells in Peiping, and is carried on wheelbarrows by the picturesque water-carrier to the home and sold for one or two coppers a pail; quite an item in the daily expenditure of a family when one realizes that the annual income for this group is $100 to $150 Mex., for a family of five or six.

Sometimes many families live in one courtyard and in a way these may be compared to our city tenements. Human excrement is collected daily in wheelbarrows, called "honey wagons" and taken outside the city walls to dry. This is later used as fertilizer by the farmers. Nothing can be wasted in China.

In summer the family lives out of doors entirely and the young children wear little or no clothing; while in winter they wear heavy cotton padded gowns.

Modern medicine was unknown to this group, so you may imagine the awe and contempt which were rampant during the summer of 1925 when the old Buddhist temple was being reconditioned. Being ignorant, they were distrustful and full of morbid curiosity. Daily, during the renovating, noisy crowds gathered in the courtyards, watching the

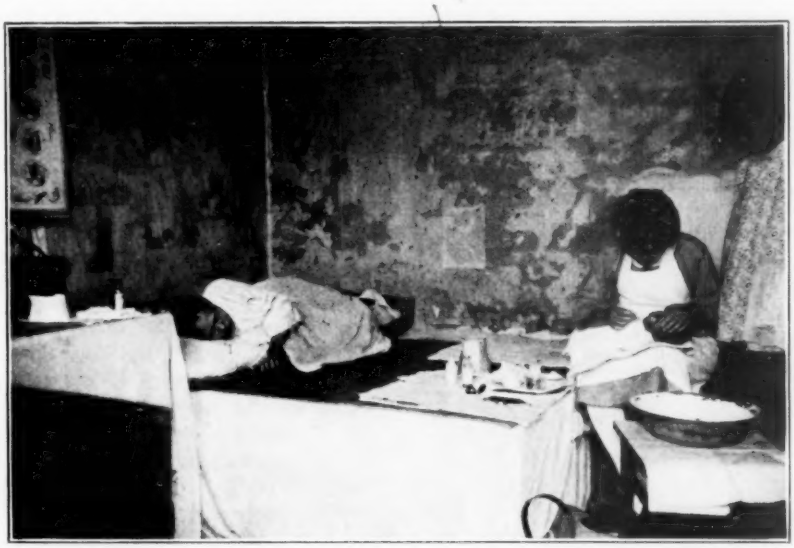
removal of the dusty old gods from the niches and thrones whence they had so majestically ruled through the centuries; viewing quizzically the installation of pipes and wires, having great fun turning on the faucets and wondering why the water rushed so plentifully into the white basins; pressing the electric buttons to watch the lights pop out in the little glass bulbs. They could not be sure whether these were Chinese or foreign devices and if the latter—well, the best way to describe their feeling is in their own Chinese idiom—"Full of hate."

IMPORTANCE OF THE DEMONSTRATION

The organizers of the Health Station were cognizant of what was going on in the community and they were most anxious to overcome all these fears and prejudices, for on this venture rested the success of public health in China. If this Health Station was a success then others would open, not only in Peiping, but in other provinces of China.

The Administration of the Health Station started with three divisions, the Division of Medical Services, the Division of Vital Statistics and the Division of Sanitation. Public health nursing was one of the first functions to be undertaken by the Division of Medical Services.

Looking across the Pacific at the way public health nursing developed in America, generalized nursing seemed to be the logical service to develop first. Graduate nurses, without any specific training in public health other than a few demonstrations in nursing techniques, were thrust into the field to make a house-to-house canvass and to demonstrate the adequate care of the sick in the homes where illness existed. This was a pretty tough job and these first Chinese nurses had a hard battle to fight. Their blue uniforms were semi-foreign in style, doors were slammed in their faces, children threw stones at them and called them foreign devils. Nothing deterred them, however, and they kept right on, but the generalized work was not successful. The community was not educated to allow strangers to enter the homes to give care to the sick. First, they were afraid they would poison or use magic on them; second, the Chinese home, especially in winter, does not lend itself



Demonstration baby bath. The bed is built in like an oven and in winter a fire is placed in it for warmth

to bedside care; third, there was no medical group in private practice in Peiping.

But as this is a practical world with a birth rate of 30 per 1,000 in this district, it was soon obvious that the mothers needed care and were calling the nurses to assist them. This service went on gradually increasing each year, and in 1929 the Division of Public Health Nursing was created to organize and develop all nursing services in the community.

Teaching the care and preparation of food in the home

MATERNITY AND CHILD CARE

This service had taken precedent over the generalized work and grew so rapidly that the area had to be increased to include the entire First Inner Ward, approximately 100,000 population. The program now covers the complete cycle of pregnancy and the follow-up of infants during the first year of life; antepartum home and clinic visits, a twenty-four hour delivery service, postpartum home and clinic visits; reporting and registration of births and deaths; supervision of old type midwifery cases; well baby clinics, mothers and preschool children clubs. The New York Maternity Center record has been translated into Chinese and a few changes made to meet the local conditions.

SCHOOL AND INDUSTRIAL NURSING

This service runs second to maternity and child health and was first sought by two large private schools and one government school. These school services were hardly organized when the Board of Education requested three nurses to look after all the primary schools in Peiping, about 20,000 school children. This was a colossal undertaking, as there were no more nurses available to do this work, but it was felt that it was better to make a beginning than to wait. For economic reasons, it has been necessary to develop two grades of school and industrial nursing—the "A" type and the "B" type. The "A" requires the full-time service of a nurse and doctor in the school or industry. The "B" type provides that the nurse and doctor have several schools or industries to look after. These two services are sold to the school, firm or Board of Education and the amount paid per capita to the Health Station determines the type of services rendered.

Industrial nursing has been developed along the same lines. The Division of Public Health Nursing is responsible for the supervision of these services and all school and industrial nurses meet regularly with the other staff members for conferences and lectures.

COMMUNICABLE DISEASE NURSING

Little has been accomplished yet in communicable disease nursing and tuberculosis control, due to the poor economic conditions of the community, nor can we hope for any great improvement until these conditions adjust themselves. Home visiting includes the demonstration of bedside care of the sick, health education, isolation if possible, reporting of active cases, contacts and suspects, prophylaxis and immunizations. Clinics too, are conducted as a part of this service with the hope of establishing a

"consciousness" in the community of the prevalence of these diseases.

RURAL NURSING

With 85 percent of China's vast population living in the rural areas this will be one of the most important fields to develop for the public health nurse. At present, the Health Station and the Tingshien Mass Education Health Department coöperate, and nursing students are sent down to Tingshien for one month's practical experience in the field. This, however, is just an experiment for the present and there is hope that it will serve as a basis for study and the development of a practical rural nursing system for China.

Student class 1931 preparing for public health nursing

HEALTH EDUCATION

The Chinese public health nurses place far greater emphasis on health education than they do on bedside care. This is due to the great love and respect that the Chinese have for education. Classes in child care, home hygiene and sanitation, preparation of foods, first aid, etc., are conducted weekly for the general public. These are attended by both sexes, of all age groups, and the attendance has been so large that they have had to limit the class enrollment.

The attitude of the community has gradually changed from a hostile to a friendly one and the public health nurse has become so popular in the district that the demands for her services far exceed the supply of nurses available in China.

EDUCATION OF THE PUBLIC HEALTH NURSE

The evolution of the public health nurse is as interesting as the growth and development of public health nursing. Since the September morn when the first two nurses walked through the moon gate to the hutung (street), stepped into their rickshas and were whisked away to unknown homes, the public health nurse has been going through a metamorphosis. Unlike her sisters across the seas, she is alone in the field with no other workers to supplement her deficiencies and she herself was soon conscious that she was unable to do a good job, unless she had specific training for it. Again the United States was taken as a model and courses were arranged for the graduate nurses, ranging from the introductory two

months to six months. None of them was satisfactory. The local needs were then studied and in January 1930 a new curriculum in public health nursing covering an academic year and based on these needs was submitted to the National Ministry of Health at Nanking. This curriculum was approved and the Health Station was designated as the official training center for public health nurses in China and a certificate in public health nursing was offered by the government to all nurses successfully completing the course.

The lectures have been translated into Chinese and are given by Chinese instructors only, as the majority of the Chinese nurses do not speak English.

This course by no means solves the problem which needs further study, as the public health nurse in China meets many problems and situations which public health nurses in America never encounter and her education and training must be based on these needs, rather than on foreign precedent.

Of paramount importance to her development are an understanding and knowledge of sanitation and of economics and the important rôle they play in the social reconstruction policy of any health program in China.

Then, too, the public health nurses objected to the Chinese name "Hu Shih" as it implies the care of the sick only and they felt it debarred them from the home when there was no sickness. When answering "hu shih" to the proverbial "Who is there" the retort was, without bothering to open the door, "Nobody sick here." As their job was to gain entrance to the home at any cost, they decided in 1930 to make the following drastic changes when the first class registered for the year's course in public health nursing:

To change the terms "Hu Shih" to "Chuan Tao Yuan" which means "to lead to health" or "health teacher."

To change the uniform to the characteristic echang, (one piece dress) with very small white collar and cuffs.

To wear no hat in summer, as Chinese women seldom wear hats.

To write all records in the office as families who could not read were suspicious of them.

All the changes went into effect at the same time and there was a marked increase in the number of productive visits in the home, as well as an increase in attendance at the preventive clinics of the Health Station.

The attitude of the community has comp'etely changed towards modern medicine and the public health nurse is no longer the object of ridicule or scorn in Peiping. She has become a respected and much loved member of the community she serves.

The male nurse also plays a very important rôle in the public health nursing program of China and his services are utilized in all fields other than maternity.

Graduates of the public health nursing course, after spending one year in the field at Peiping have gone elsewhere in China to organize public health nursing. Four are in the Health Department in Shanghai, three in Canton, four in Nanking, three at Yale in Changsha and one in Chungking, the far away province of Szechuan.

The old Buddhist temple has long since lost its foreign savor and the community is now availing itself of the health services offered there; extensions have been added to allow for the hundreds who visit daily seeking advice and help, and 89 percent of the attendance at the preventive clinics is the result of a "Home Visit."

Public health nursing has developed, not as an independent organization establishing its own nursing services, but as a major function in the social reconstruction policy of an organized community health program.

The Conquest of Congenital Syphilis

By M. J. EXNER, M.D.
American Social Hygiene Association

The American Social Hygiene Association is naturally deeply concerned with the problem of conquering congenital syphilis. To this end it is calling on the coöperation of all public health workers to lend their strength and interest to a campaign to bring this disease and the methods of its control before the public. We are glad to offer to our readers Dr. Exner's authoritative statement of the situation and to ask special effort on the part of our lay and professional readers to work toward blood tests for ALL *expectant mothers, and early and adequate treatment with careful follow-up on all children born of syphilitic parents. The American Social Hygiene Association* will be glad to furnish further information or answer questions on any phase of this subject.*

CONGENITAL syphilis is the term applied to syphilitic infection acquired by the child from its mother in her womb. All syphilis is terrifyingly serious both because of its destructive powers and its disrupting tendencies in family life. It is estimated that in the United States annually approximately 100,000 deaths, including stillbirths, are attributable to syphilis. Because of its moral implications the advent of syphilis in the family always carries with it the likelihood of unhappy, disrupting or tragic consequences.

Congenital syphilis is the most tragic of all the manifestations of the disease. It is pitiful in that it attacks the individual in the very process of formation as a human being and kills him before he has seen the light of day or fastens upon him crippling handicaps for life. Indeed, in view of the seriousness of these handicaps, the infected children who are born dead have sometimes been considered the more fortunate. Congenital syphilis is the most destructive form of the disease and offers the least favorable possibilities of cure. Acquired syphilis in the adult wears its devilish mien only when it is neglected or inadequately treated. When early and adequately treated a permanent arrest or cure can be accomplished in virtually all cases and all of the destructive possibilities can be prevented. Not so in congenital syphilis. While much can be done by timely treatment, the possibilities for cure are as yet limited and with every postponement of treatment the chances rapidly dwindle.

This is illustrated in the results of Jeans and Cooke who employed only thoroughly modern methods of treatment. One hundred and twenty-five children under one year of age received treatment for six months or more. Of these 90 (72 per cent) remained "cured" at least three years; 35 were not serologically "cured." Sixty-six children over one year of age received treatment more than six months but less than a year. Of these 8 (12 percent) were cured and 58 were not serologically cured. Of 193 who were treated more than a year, 85 (44 per cent) were cured; 108 (56 per cent) were not serologically cured. These data throw forceful emphasis upon the need for early and adequate treatment, but even at best, the possibilities are limited.

We are handicapped in the treatment of children born with syphilis in that we cannot begin treatment in the early stage of the infection as in the primary stage of acquired syphilis in the adult when the chances for cure are greatest. We do not see the "primary stage" in congenital syphilis. Its early manifestations are those of the secondary stage in the adult. The disease is already generalized, and in the adult by the time the secondary stage appears the chances

*50 West 50th Street, New York, N. Y.

for cure have been already reduced by about 21 per cent.

The disruptive tendencies of congenital syphilis in family life are peculiarly great. It stirs the deepest human emotions, prone to arouse bitterness, aversion and hatred more than any other appearance of the disease in the family. A saving adjustment of relationships after transmission of the disease from one marital partner to the other is often possible, while such a happy outcome may be frustrated by the appearance of the disease in the child.

SYPHILIS IN PREGNANCY

Syphilis in pregnancy and its consequent transmission to offspring must be of deep concern because of its prevalence. In 14 studies of women attending prenatal clinics the presence of syphilis was discovered in from 3 to 23 per cent, varying with the economic and social status, the average prevalence being almost 10 per cent. It is difficult to ascertain the approximate prevalence of syphilis in women of the better class because so rarely do private practitioners make routine use of the blood test in the examination of pregnant women. In certain studies, however, of the private practice of obstetrics, 0.3 to 2 per cent of pregnant women were found to have syphilis.

The serious import of syphilis in pregnancy lies in the fact that the vast majority of syphilitic pregnant women, when not treated, transmit the disease to the fetus or child before birth, and the fact that the results in the offspring are so destructive. Only about 15 per cent of the offspring of syphilitic women are healthy, non-syphilitic children. About 85 per cent are either born dead (25 to 40 per cent) or die in early infancy or survive syphilitic and subject to all the maiming, crippling consequences of the disease. Four times as many abortions occur in syphilitic women as occur in non-syphilitic women.

AMONG CHILDREN

From various studies the prevalence of syphilis among children of all ages, in the child population as a whole, is estimated to be from 2 to 3 per cent. Among children of all ages attending one large clinic, syphilis was discovered in 2 percent. When the children were classified according to age, however, the rate among children of one year of age and under rose to almost 5 per cent, reflecting the very high death rate of syphilitic infants. Studies of various other clinics also reveal 5 to 6 percent syphilis among infants under one year of age.

Most living syphilitic infants do not show evidence of the disease at birth. When it does manifest itself so early it usually means a particularly virulent infection. In about two-thirds of syphilitic infants clinical manifestations appear within the first two months, and in but few cases are they delayed beyond six months. If the mother has been found to be syphilitic and has not been treated for syphilis during her pregnancy, it is advisable to begin treatment of the child at once without waiting for clinical symptoms of the disease, provided the blood test for syphilis is positive. If negative, repeated tests at short intervals should be made.

The obvious manifestations of syphilis in the infant are chiefly those of the skin, mucous membranes and bones, and to some extent of the nervous system. Occasionally the eye is involved. After the disappearance of early skin eruption there may be a recurrence of a variety of different types of syphilitic manifestations.

The lesions of late congenital syphilis, appearing mostly between the ages of two and fifteen, are chiefly those of the eye, mostly keratitis; syphilis of the nervous system; bone and joint syphilis; deafness and destructive tumor-like growths called gummata. In one clinic, 63 per cent of the children over five years of age with clinically active syphilis had interstitial keratitis. In neglected cases keratitis usually impairs vision or causes blindness.

The involvement of the nervous system is the most serious result of late congenital syphilis, for by the time that neurosyphilis is clinically recognizable, the damage already done is beyond repair. Motor paralyses and mental de-

terioration are usually the most prominent indications. Syphilitic dementia, paralysis of the insane, and sometimes tabes dorsalis (locomotor ataxia) are the extreme results.

Practically all syphilitic infections in children who survive become latent at some period during the disease and the period of symptom-free latency may continue for a number of years. In the Jeans and Cooke series more than half of the syphilitic children beyond infancy manifested no signs of clinical activity when the child was first seen.

While diagnostic signs and symptoms of syphilis may not appear for some time after birth, the general appearance of an infant will often suggest its presence. Schamberg and Wright thus describe the clinical picture: "The facies as in the newborn congenital syphilitic have a senile appearance; the child is feeble and debilitated; the skin is a brown or café-au-lait color and is wrinkled and withered; the eyes are sunken with the conjunctivae of a bluish color. The feebleness of the child is evidenced in an inability to take milk from the breast. Crying is almost constant, more so at night, and the cry has a peculiar aphonic sound. The child sleeps but little. Even before the appearance of cutaneous or mucous membrane lesions the above signs should lead to a suspicion of congenital syphilis." When newborn infants present these characteristic clinical appearances and active syphilis is present in the parents, treatment of the child should be begun without further loss of time.

ONE HOPEFUL NOTE

While the prevalence and the destructive results of congenital syphilis present a very somber picture, the cheering and challenging fact about it is that it is entirely preventable or controllable by treating the syphilitic pregnant woman during her pregnancies. By timely treatment with modern methods the transmission of the disease to the child can be prevented in almost all cases so that healthy, non-syphilitic children are born of syphilitic mothers. No more dramatic result is accomplished in the whole realm of preventive medicine.

The available evidence indicates that the disease is transmitted from mother to child in the majority of cases after the middle of the period of pregnancy by way of the placenta. This is an observation of tremendous importance. It leaves a period of a number of months for the discovery of syphilis in the pregnant woman as part of her physical examination and for instituting treatment for the protection of the child. Large experience has shown that if the syphilitic pregnant woman can begin treatment by the middle of the period of pregnancy and receive adequate treatment (at least 10 doses of arsphenamine and 10 doses of bismuth or mercury) the transmission of the disease to the child can be prevented in at least 95 per cent of cases. In a considerable proportion of cases even much more limited treatment given in the last months of pregnancy serves to protect the child. Hence while for the sure protection of the child it is of utmost importance to begin treatment early, it is advisable to treat the woman at any period of pregnancy in which syphilis may be discovered up to the time of delivery. A study of treatment in five coöperating clinics indicates that when adequate treatment is instituted before the fifth month, a living, apparently healthy child will result in 91 per cent of cases. In fact in this group only one child in 43 was born dead.

Treatment of the syphilitic pregnant woman is aimed primarily at the protection of the child. It is not likely to be adequate for a permanent arrest or cure of the disease in the mother. To this end her treatment needs to be continued as soon as it is possible after the birth of the child. Inasmuch as we cannot be certain when the spirochetes have been completely eliminated from the body, the woman should receive protective treatment in all succeeding pregnancies regardless of previous treatment.

Apparently the duration of the infection in the mother influences the manifestation of syphilis in the child. Schamberg and Wright say, "We believe it is not rare for children of luetic parents born some years after infection to be free of ascertainable manifestations and

with a negative Wassermann who nevertheless harbor spirochetes within them."

The conquest of congenital syphilis depends upon the early diagnosis of the disease in every infected pregnant woman, followed by early and adequate treatment. Clinical manifestations can rarely be relied upon for the diagnosis of the disease in any of its forms and least so in pregnancy, for pregnancy itself exerts a powerfully inhibiting effect upon the manifestations of the infection. Our chief reliance for diagnosing syphilis in pregnancy must be the blood test—Wassermann, Kahn, Kline, Eagle, Hinton and some others now recognized as useful. Frightful as the malady of congenital syphilis is, its prevention is theoretically a comparatively simple problem, namely (1) the inclusion of blood tests as part of the physical and health examinations every pregnant woman should be given early in her pregnancy, and (2) the prompt treatment of those found to have syphilis.

There exists, unfortunately a loophole. In not a few cases the routine blood test may be negative while the woman remains potentially infectious as regards the fetus or child. However, in most of these cases repeated blood tests at short intervals will reveal the disease, and this procedure should be followed in all cases where any reason exists for thinking the disease may be present and those which give any history of infection. In every case of syphilis discovered in one member of a family, it is important that all the other members of the family be examined, including a blood test, and that those found to be infected be brought under treatment.

ROUTINE BLOOD TESTS ESSENTIAL

A good deal of progress has been made in recent years in the extension of the practice of routinely making blood tests for syphilis upon all pregnant women. This practice is coming to be fairly common in prenatal clinics and in obstetrical practice, and hospitals are increasingly adopting it. No medical service dealing with pregnant women can any longer be regarded as modern which does not follow this preventive procedure. It is to be hoped that the same attitude will come soon to prevail among physicians in private general practice. It is in this field that progress in this matter most lags and halts. Some fear to offend their patients by taking blood for a test. Others feel that syphilis does not occur in private practice with sufficient frequency to justify the routine blood test upon all pregnant women. Moore of Johns Hopkins, speaking on this point says that while at a guess it would probably be necessary to make 200 tests to get one positive in private obstetrical practice the procedure would be abundantly justified and worth while if the ratio were 1 in 1,000. Certainly the woman of high social status cared for in private practice has as much right to be protected by this precautionary measure as the indigent woman in a public clinic.

Another important feature in the conquest of congenital syphilis is the education of the general public in reference to it. On the one hand the physician must be alert to discover syphilis in his patients, and on the other hand women must come to accept the making of a blood test as a matter of course as a part of their physical examinations and to welcome it rather than resent it, if this scourge is to be conquered. In the promotion of such education the organized medical bodies and the official and lay public health agencies need to bear a large share of responsibility. Something is also to be expected of our schools and colleges in the way of including information on this subject in health teachings.

No one has a better opportunity or more favorable conditions for imparting to women the needed information and creating a wholesome attitude than has the public health nurse in her contacts with them in and out of families. She has the rare opportunity of making her educational work strategically selective, reaching those who have the most immediate need. It is urgent that all schools of nursing prepare their students adequately to meet this need.

Opening Guns of a Campaign

This is part of a speech by Dr. Haven Emerson, President of the American Public Health Association, at the opening luncheon of a drive for funds conducted by the Brooklyn (N. Y.) Visiting Nurse Association. We are printing it here because it is such an excellent example of effective publicity based on statistical fact. Any other community could adapt its figures to this type of appeal.

THE Visiting Nurse Association of Brooklyn runs a hospital without walls that exceeds in capacity any seven of the large hospitals of this Borough, excepting Kings County Hospital. Each patient admitted to our general hospitals occupies a bed on the average of two weeks, *i. e.*, twenty-five patients a year to a bed when the hospital is run at maximum capacity and with utmost efficiency. If the almost 64,000 patients whom the visiting nurses of Brooklyn cared for in their homes in 1933 had been sent to hospitals instead, there would have been needed 2416 hospital beds or five hospitals each of 500 bed capacity. Each day of hospital care costs some one at least $3.50 quite apart from medical attention. Each visit of a nurse to carry out the treatment advised by the family physician costs someone $1.05.

It is not too much to claim that by making it possible to provide the skill, cleanliness, and understanding of the visiting nurse in the home, the people of Brooklyn are saved every year at least three times what they are asked to contribute to the support of the nurses.

Not only in quantity and cost of the service are you saved really very large amounts but by the quality of care you benefit in terms of life. While about six mothers die from childbirth for each 1,000 having babies born in the city as a whole, the rate is only 2.4 among the mothers attended by these visiting nurses. About 40,000 babies will be born in Brooklyn this year and it is a matter of concern to every home in the city whether 224 mothers die in childbirth or 96.

More cases of acute communicable diseases of childhood are cared for by the visiting nurses in the children's homes than there are patients with such illnesses sent to the hospitals of the city. Fewer children develop secondary and additional infections among cases of measles, scarlet fever, diphtheria and whooping cough attended by the visiting nurses in homes than occur among children admitted to city hospitals for these diseases.

In Brooklyn as in other boroughs of this city and in Boston and Detroit, where contagious diseases are attended by visiting nurses, the deaths among such patients are at a rate one-third that of the deaths among similar patients who are not so cared for in these cities at large.

Home care of cripples is provided, and every orthopedic surgeon knows how much depends on the skilled use of massage, muscle training, resistance exercises and courage and patience given by the nurse to those permanently handicapped by infantile paralysis.

If it were fully known about, the people would think of the Visiting Nurse Association as a principal institution of adult education, a university of the household, leading to higher degrees in gentleness, cleanliness, and the skill of the trained eye and hand.

No home a nurse enters but is taught not only the techniques of bedside care of the immediate patient, but the broad principles and simple rules of hygiene upon which preventive medicine is based.

No professional antagonisms hamper the nurse in her rounds, for she is backed as much by the Kings County Medical Society as by public opinion and the supervision and encouragement of her own headquarters.

A call for nursing service has never been declined. Every patient asking has been visited whether he can pay or not.

Almost thirty percent of the visits are paid by the patients or by insurance companies for their policy holders but the remainder must be met by donations from the well for the sick.

These nurses for over two years have given back five percent of their salaries to pay for more nurses to do the work. Show me another body of self-supporting women earning less than $2,000 a year who have voluntarily reduced their own salaries to help their fellows in these past years. The nurses actually have donated almost as much each year in this way as the Association receives in interest from its endowment fund.

Only once in the 45 years of its existence has any contribution been made from tax monies, and that only in the past year and from the State for nursing care of the unemployed. This grant was for $16,000 or not quite enough to pay for five percent of the nursing visits of the year.

For the distinction of priority of your Borough, for pride in the excellence of the service now provided; for the principle of economy so strikingly exemplified in the management of this institution of education in the art of healing and the practice of prevention; as a debt to the past and a promise to the future, yours is the obligation and the opportunity to double the number of nurses now employed.

How small a thing is asked of you—$200,000—only seven cents apiece for the 2,750,000 residents of Brooklyn. Ninety percent of the people could give this and not know it, or be the better for what they gave up to share a dime with the sick.

If there are 100,000 persons who can give $2.00 apiece there must be 300,000 of them. There are 300,000 families in Brooklyn with incomes of $2,000 a year or more.

Brooklyn needs now not less than 400 visiting nurses to provide needs of economical care of the sick.

If at least $200,000 is not promptly raised the 141 now at work will have to be reduced.

It is as unthinkable that there should be fewer nurses giving bedside care to the sick in their homes as that hospital wards should be closed or operating rooms vacated or the Health Department discontinue its guardianship of the health of the community.

At the beginning of this drive, in anticipation of it, the Association circularized the members of the County Medical Society so that the profession might be aware of the campaign. Included with the letter were the standing orders under which the nurses work. A paragraph in the circular letter reads:

"Be assured that we are not asking you for a personal contribution at this time. The free service rendered by every doctor in the city is more than commensurate with the contribution of others. While we will deeply appreciate any further gift you are prompted to make, we hope you will not construe this letter as in any sense a financial appeal."

For the past ten years the County Medical Society has acted, through its Committee on Public Health, as medical advisor to the Visiting Nurse Association.

Health Insurance for American People*

By JOHN A. KINGSBURY

WHY are we concerned over questions of medical economics? Is it because we have inadequate facilities to furnish medical care? Certainly not; we have nearly enough physicians, dentists, and hospitals and sufficient specialists, nurses, and pharmacists to provide all the service which medical judgment says the people need. Is it because the people are not sufficiently health conscious and are unaware that they need medical care? Certainly not; there is no nation in the world in which the desire for health and the appreciation of medical service is greater than in our own. Is it because we cannot afford good medical care? Certainly not; in any normal year we spend nearly three billion and seven hundred million dollars or $30 per person for health and medical services and this is nearly enough to buy adequate medical care for everyone.

Then why is it that in an average year 52 percent of the people receive no services from a physician, 79 percent get no attention from a dentist, 89 percent receive no health examination or similar preventive service, less than 4 percent of all adult persons receive an examination of any sort, and 62 per cent of the people receive absolutely no medical, dental, or eye care of any kind? Why is it that neither the rich nor the poor, and certainly not the great middle class, receive anything even approaching adequate medical care?

The conditions summarized are based on the unchallenged findings of the Committee on the Costs of Medical Care and refer to the heydey of the years 1928 to 1931.

The lack of medical attention in normal times is mild by comparison with that which obtains during a depression. A survey conducted jointly by the United States Public Health Service and the Milbank Memorial Fund in the early spring of 1933 showed that decline in income has been associated with an excessively high illness rate and an increase in the inadequacy of medical attendance. However, decline in income brought to the surveyed families not a reduction but an increase in hospital care over that to which people in the same economic class are accustomed. Fifty to 90 percent of the hospitalized cases among the poor received hospital service without cost to the patient. From this study we learn that large classes of the population have to suffer the catastrophe of unemployment and reduction of income in order that they shall receive hospital care!

The burden of costs on the public has its counterpart in insecurity and uncertainty of income for the professions. In 1929 one-third of all physicians had net incomes of less than $2,500 and one-half less than $3,800. If we graded private general physicians in income intervals of $1,000, more physicians would be found in the $1,000-$2,000 class than in any other. And this was in 1929! For every physician who received more than $10,000 in gross income there were *two* who received less than $2,500; for every dentist who earned more than $10,000 there were *four* who earned less than $2,500. In 1930, physicians' incomes declined 10 percent below their 1929 levels.

Group budgeting for the service of the physician has made a beginning in this country, in hundreds of fraternal orders and industrial groups. In California, and in Oregon and Washington, important medical-service plans have gone forward under the auspices of the state and county medical societies. The principle of insurance for medical costs has also been approved—in one form or other—by a number of state and local

*Excerpts from an address delivered by Mr. Kingsbury, Secretary of the Milbank Memorial Fund (N. Y.) at the Eighth Annual Convention of the Western Hospital Association, Sacramento, Calif., April 9, 1934.

medical societies and other representatives of organized medicine.

In Europe the history of insurance against illness and disability goes back many centuries. It grew out of the pooling of funds in the trade guilds and mutual benefit associations. Early in the nineteenth century the movement received a fresh impetus when several countries established national systems. In 1883 Bismarck gave compulsory sickness insurance to Germany. Now some forty countries of the world have health or sickness insurance systems, twenty-two being entirely on a compulsory basis and the others involving legal or economic compulsion in greater or lesser degree. In Russia, medical care has been made a public service. In England, in addition to the fact that sixteen million persons are included in the compulsory system of insurance which covers the services of the general practitioner of medicine, some six million persons voluntarily insure for hospital care. The lessons from this experience are ready to our hand.

How shall we meet our American problems? How shall we formulate a sound program of insurance against medical costs? Two of my associates, Dr. I. S. Falk and Mr. Edgar Sydenstricker, are making a careful study of these questions. Their report is not yet complete; at this time I can only offer their tentative conclusions and my own; and I present these not as definite proposals, but only as a basis for constructive discussion.

1. *Which fractions of the population should be covered by the plan?*

In Europe and in America, it has been customary to restrict health or sickness insurance to those who earn small wages, generally less than $1,200. All European and practically all voluntary American systems are poor-man's systems and are geared to the financial resources of the poor. Only by carrying an excessively large panel of patients can the physician earn a decent income in a poor-man's system. Physicians and other practitioners in America who endorse insurance against medical costs only for the lower income brackets fail to realize that they spite both themselves and the public.

Our primary problem is not how to furnish financial assistance to the poor, but to enable those who cannot buy medical care as individuals to buy it as groups. Sickness insurance should apply to all families with annual incomes of less than $3,000 or $5,000, and preferably should permit insurance of all persons and all families in the population. We want no poor-man's system in America.

It is clearly desirable to coördinate an insurance program with other official and voluntary health and medical activities. The necessity for support from tax funds leads us to the conclusion that an insurance system should be organized on a state-wide basis.

2. *Should the plan be voluntary or compulsory?*

European experience shows clearly that every voluntary scheme is merely a bridge to a compulsory scheme. Experience is accumulated through voluntary insurance, and this is very useful in the establishment of a compulsory system. Unfortunately, many of the worst abuses which develop under voluntary schemes are carried over into the compulsory stage and remain to confuse the new administration and to interfere with efficient operation.

The people in the lower income brackets, who most urgently need an insurance plan, show the greatest inertia in coming into a voluntary plan. The poor, the mass of workers, can be only partly, if at all, covered by voluntary insurance, and our society has no protection against the burdens which they carry and create. If insurance is to cover the people whom it should, it must be grounded on a compulsory basis.

3. *What medical services should be furnished?*

Medical benefits in an insurance program should be divided into two classes.

The first should include the general practitioner, hospital care (where sufficient hospital beds are available in the

community), and perhaps prescribed medicines. These services should be mandatory. The second class might include other medical services, such as those of the medical specialist, dentistry, home nursing, laboratory and clinic service, home remedies and medical commodities. These might be made permissive for each community which desires them, has the means to pay for them and the facilities to furnish them, and proposes a scheme which receives the approval of the proper insurance authority. It is conceivable that even the second class might be made mandatory as rapidly as the personnel and facilities can be made available.

Our studies convince us that cash benefits to replace wages lost on account of illness should not be provided in this system, if the need can be met in some other form of social insurance.

4. *How shall practitioners and institutions be remunerated?*

Our studies show that it is possible for a system of compulsory insurance to keep the costs of medical service within the means of the public and yet pay the practitioner a fair return for his service.

Just how he is paid can be determined by the organized groups of practitioners in each local area; they can be permitted to choose a system based upon salaries or annual fees per person, or fees per unit of service. In any case the general practitioner can be paid a sum equivalent to at least $7.50 per insured person. A very tentative estimate may be ventured, and under such an estimate the general practitioner who serves 1,000 potential patients would receive a gross income of something like $7,500; the practitioner who serves 2,000 obviously would receive more.

Experience shows that the costs of hospital care can be adequately met from an insurance fund for a reasonable cost. In principle, all that is needed is an arrangement whereby a non-profit insurance fund agrees to remunerate each approved hospital at a fixed sum for each patient-day of service rendered to insured persons. The insurance risk is carried by the insurance fund, not by the hospital. Such arrangements can be proposed whether the hospitals are owned by governments, by non-profit corporations, or by private individuals.

Similarly, it is possible by facing each question on its merits to work out a scheme whereby each additional type of medical practitioner or institution may be adequately remunerated at a cost within the means of the system, and through such arrangements as are mutually satisfactory to the public and to the medical agencies.

5. *What would be the total costs of the medical benefits?*

For medical services furnished through an insurance system, in adequate volume and of high quality, the cost would be about $36 per person. This includes not only the services of the general practitioner, the medical specialist, the dentist, the graduate and the practical nurse, the general and special hospital, drugs and medicines, laboratory, etc., but also the cost of adequate tuberculous and mental disease hospitalization, all desirable forms of public health work, the costs of administration and of a contingent reserve. The medical services of the kinds which are ordinarily purchased privately would cost about $27 per person. The customary expenditure is $23 to $24 for similar services, but our conception of medical service calls for much larger volumes of medical care than either the rich or the poor ordinarily receive.

The basic problem is not to find more money than is now spent, but to find new and better ways of directing customary expenditures into more productive channels. Any community which might adopt less than the complete program would, of course, have proportionately smaller costs.

6. *How shall the funds be raised?*

In the United States in general, it has long been customary for approximately 14 percent of the costs of health and medical care to be financed through tax funds. In our proposals, services of the kinds ordinarily financed from tax funds account for 20 percent of the budget. We may therefore assume that at least

this much might continue to come from tax funds under an insurance program. How shall we distribute the remaining 80 percent? Some might argue that all of it should come through taxation which places the burdens upon various groups in the population.

Others will contend that the 80 percent should be raised through direct contributions of the insured persons.

Some will argue for contributions shared between employed persons and their employers.

In every case, tradition and practical considerations agree that the costs must be distributed according to ability to pay.

7. *How shall a health insurance program be administered?*

In any administrative arrangement that may be devised in a state, it seems to us essential that provision should be made for *lay* supervision of financial and executive problems and for *professional* supervision of professional personnel and professional problems.

Our studies of European and other health insurance systems lead us to believe that three types of agencies, closely coördinated, should be provided: executive agencies to set up and administer the scheme; a professional agency to care for the problems of education and investigation and to administer professional service; and a judicial agency, combining lay and professional members, to deal with complaints and grievances.

Such an administrative scheme would recognize that certain basic services should be made mandatory for all insured persons in the state and that the scope of additional medical services should be determined by local needs, local ability to pay the costs, local availability of facilities and local initiative in formulating a program. Perhaps such a program lays too much responsibility in local—as distinguished from state—authority. The point requires further study.

European plans for health insurance have never dealt adequately with preventive care. It seems essential that an American plan should place adequate emphasis upon the prevention of disease.

We therefore propose that periodic physical examinations of all insured persons by their physicians, immunizations, prenatal and postnatal care, etc., should be required. And we would include arrangements for special payments or bonuses for these services. In respect to health care for large groups or for entire communities, an American plan should provide coördination between the insurance system and all other agencies devoted to the prevention of disease.

Fortunately, there is no real conflict of interest among the three parties concerned with the economics of medical care—the public, the practitioners and the institutions. Leadership must come from each of the three groups. It must always be remembered, however, that the public "foots the bill" and, in any final sense, the public will decide.

Nursing in the Mountain Forests of Peru

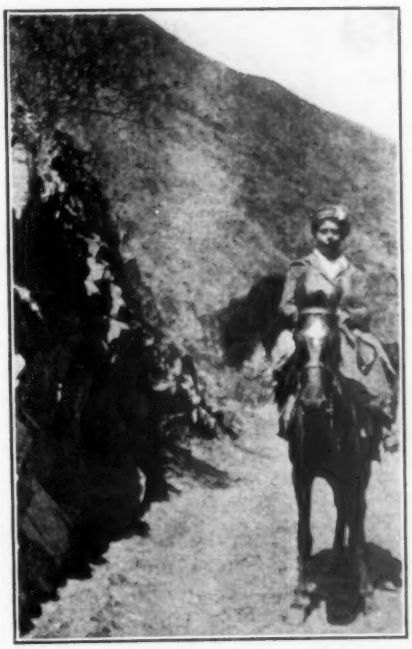
By ANNIE G. SOPER

Editorial Note: We consider it a privilege to reprint in part an account of a public health nursing experience in the mountain forests of Peru. We are indebted to *The Nursing Times* (England) for this material and to Mr. W. Soper, brother of the author, for the pictures. Moyobamba is in northern Peru, and Miss Soper has been carrying on—under enormous difficulties—health and missionary work there under the title "The Lamas Evangel."

AFTER a heavy day, which terminated with giving a Bible study at the mid-week service, I arrived at our sleeping place longing, as usual, for rest. For a short time we—my fellow workers and myself—lingered to talk over the events of the day; then we retired, each to her own room.

With a sigh of relief I settled down comfortably in bed, feeling how good it was. But sleep refused to come, only a whirl of plans and confused thoughts, until, with a start, I realized some one was knocking frantically at the door, dogs were barking and voices talking. With the usual sinking of heart, knowing it must be something urgent at that time of night, I went to see, and to my dismay found it was a call to a village three hours' journey away, to a woman who had been "days" in labor, and the arm presenting for some hours. Could I go? The long, weary, well-known journey, my own tiredness, the many duties I must leave, the practical impossibility of saving the woman, the many other people in the village who would beg for attention—all these thoughts and more crowded through my mind quicker than I can write them. I called my colleague; she, too, hesitated as to where our real duty lay, but was ready to accompany me.

We were soon on our way, the two animals brought for us galloping along as if they understood the urgency of the case. About three a.m. we arrived at a river, only to find the boatman on the other side, and evidently fast asleep, for no amount of ringing the bell and shouting secured any response. I wonder how many can imagine our feelings stranded there, knowing how precious were the moments, having visions of a ruptured uterus and other emergencies, and being so helpless although only the river now separated us from our patient. We could not swim across; the current is too strong even for very strong swimmers, and we were neither of us that. After what seemed an interminable wait a light appeared on the other side, and with some delay the canoe began to move, and soon we too were once more on the move.



The author on the Andean Mountains

We found, as usual, the house full of people, with our poor patient standing in their midst, being urged to use all her strength. She was a big girl of seventeen years of age; it was her first baby, and the arm had been born as far as the shoulder since five o'clock the

previous morning. The home was indescribable, the floor of mud, the walls unfinished and not even whitewashed, the only ornament a shrine cut in the wall for a saint, the only light a piece of raw cotton soaked in oil. My request for water to wash hands brought, after much delay, a teacup three parts full.

Most of the people had disappeared, evidently frightened of the "heretics", as we are called by the priests. After much fighting I managed to procure a lamp and basin, borrowed from the few homes that possess such things, water was put on to boil and there was a fair amount for washing hands and such purposes. The disinfectant had to be put into a douche can, which, fortunately, we had brought. During these activities my colleague was preparing the patient and the anaesthetic, for we knew little could be done without that.

The Hospital at Moyobamba

On examination I found matters as I had expected—the head fixed on the breast, the neck wedged tightly down, the uterus in a state of almost chronic contraction. All things considered the condition of the patient was fair, but there was a high fever and the pulse rate was about 120.

After putting the patient completely under chloroform I endeavored to get the child into a possible position. In other such cases I had been successful in bringing down the feet, but in this case, though I had tried from every possible direction, I could find nothing more than the presenting parts. To get into the uterus seemed impossible and I was afraid to use force; the thought of rupture haunted me. For about two hours we continued thus. Nurse Gould, my colleague, was in a cramped-up position giving the chloroform, I working and crying to God for help, sometimes aloud and sometimes even more earnestly in thought. No one would help me; whenever I wanted anything I had to take away my hand, wash up, go through all the performance of scrubbing up, sometimes for a thing just out of my reach. There was nothing of any description to put the bottles on. The sole furniture of the room was a bedstead of bamboo canes, with no mattress; on this was our poor patient. On the other side of the room was a heavy wooden form. Many times it seemed impossible to go on. Once I just managed to reach a foot and pull it down and get my hand on the other foot when the patient collapsed, and there was nothing for it but to wash quickly, help with restoratives, and give injections. Much precious time was thus lost.

The risk of giving more chloroform was great, yet the uterus had by this time contracted, so there was nothing for it but to take the risk, and this time I was successful and within a few minutes had the child into the world stillborn, the placenta extracted, a hot intra-

uterine douche given and the patient made as comfortable as possible on her comfortless bed.

It was broad daylight by the time we had finished washing the patient. I was a sight to behold. In spite of overall and apron my garments were splashed badly. The water supply had come to an end and there was nothing for it but to go to the river and get myself as clean as my tiredness would let me. No one seemed to think *we* needed anything, and of course we *should not* think of ourselves, but we were so faint and weary. Just a cup of tea or coffee would have brought us back to life. However, we waited on, watching our patient closely. Just as she began to open her eyes a gentleman whose family we had attended on other occasions and who had advised our being sent for in this case, came and said he had breakfast waiting as soon as we were able to come. Gladly enough did we accept as soon as the young girl was well awake. We then found, as usual, a number of patients wanting attention, and our morning was spent visiting between them and our first patient, until in sheer desperation we escaped to the river where, lying flat on the ground with our helmets to protect our faces from the fierce sun, we slept for about an hour before making a final visit to our patient and starting homeward.

How anxious were the following days! When the message came on the third day to say there was fever how gladly would I have gone again, but other duties were more urgent. A few days after, however, came the welcome news that the fever had not lasted and the patient was eating and sleeping, had no pain, and beyond her weakness was quite all right. How fervently we thanked God. He had performed another miracle.

There are probably many nurses who, on reading this, will say—"What right have you, as a nurse, to do such things? Why did you not call in a doctor?" They have a perfect right to ask such a question, but when I tell them there is no doctor where we are, even though it is a town of 12,000 inhabitants, and that the Government doctor lives in another town three hours' journey in another direction from the one we visited, they will understand why these poor folk come to us. Many of these young girls are left to die in like circumstances. Our regret is that physical strength does not permit our answering all the calls. In fact we generally refuse normal cases and attend only complications.

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR AUGUST

Public Health Nurses and Cardiac Patients

By VERA J. McKINNON, R.N.
Cardiac Nurse, Visiting Nurse Association, Minneapolis, Minn.

MRS. ADAMS, a widow and sole support of four children, was on the verge of a complete physical and mental collapse when the visiting nurse discovered her. Not knowing the nature of her frequent "attacks" she was afraid to venture out alone, and was greatly depressed over what she considered her inability to work. Her condition was not apparent in her manner and looks, therefore she received small consideration from her family and friends. Thus her days were filled with worry and introspection.

This being the state of affairs when the visiting nurse arrived, a visit to a clinic followed. Here it was discovered that Mrs. Adams was suffering from a severe heart condition, and plans were immediately made for treatment of her particular case. During the weeks that followed, the visiting nurse paid daily visits. She watched the pulse and blood pressure of her patient, as well as the effect of medications given. Mrs. Adams coöperated with the nurse in following out carefully a diet and regular rest periods.

The next step in putting Mrs. Adams back on the road to health and efficiency, was taken by the clinic social worker. She explained to Mrs. Adams' employer the acuteness of the situation and gained his coöperation in allowing Mrs. Adams freedom from heavy work, and continued rest periods. The visiting nurse called the children together, and by pointing out their responsibility to their mother and their home, was able to effect a program of work within the home. Each child, including the seven-year-old boy, was taught to do his or her own ironing. The nurse took the time to explain Mrs. Adams' state of health to relatives and neighbors. She emphasized the need of rest for Mrs. Adams, and as a result secured their aid rather than their criticism.

During the months that followed, Mrs. Adams was able to continue in the support of her family. She has had no further heart attacks. Her mental attitude has changed toward herself and her physical well being because she realizes her limitations, and with the help of the nurse, has been able to make a sane adjustment to her handicap.

The case of Mrs. Adams is a striking example of the results which may be obtained with patients afflicted by heart disease. These results, however, can be obtained only when physician, social worker, and nurse coördinate their activities for the good of the patient.

THE SERIOUSNESS OF CARDIAC CONDITIONS

Heart disease now looms large on the horizon of human maladies. It deals a double blow to mankind not only because it causes more deaths yearly than any other disease, but because it is also first in the damage it does toward disability and invalidism. Among all fatal and serious diseases, it has the record of being longest in duration. With the possible exception of certain mental diseases, heart disease can also form the most persistent handicap in self-maintenance.

With these facts in mind the Visiting Nurse Association of Minneapolis initiated its Cardiac Service in October, 1930. Convinced that heart disease was one of the most serious of modern day health problems, the Association set aside funds for continued service and treatment. The willingness of the medical profession to accept the help of the nursing association in this program, was of paramount importance. The Minneapolis Visiting Nurse Association was fortunate in obtaining this coöperation from its Medical Advisory Committee and from the County Medical Society.

Dr. George Fahr, supervisor of the

adult heart clinics in the public hospitals of the city was the originator of the plan, and gave generously of his time to the instruction of nurses for the special techniques required. The doctors of the children's heart clinic at the General Hospital also welcomed a cardiac nurse, and urged that all visiting nurses be on the alert to refer for examination children with symptoms of rheumatism.

FROM SPECIALIZATION TO GENERALIZATION

With extra expense financed first through private donations, and later by the Community Fund, one of the visiting nurses was selected to attend heart clinics and to make home visits on cases referred. She received special instruction in the taking of blood pressure and accurate apical as well as radial heart count. She learned also the significance of such symptoms as cyanosis, breathlessness, edema, and to note reactions to various medications. She found that diet is most important in the treatment of heart disease, as is also the elimination of focal infections. In short she learned to observe significant symptoms which should be reported to the doctor, and she learned the special things in the management of heart disease which she, as a home visitor, should teach patients and their families.

Gradually this nurse was able to pass on her special knowledge to other members of the visiting nurse staff. Then, as the case load became too heavy for one, she transferred the surplus number of patients to nurses of the various districts. She now acts as special consultant for all cardiac cases carried by district nurses, while she herself continues to visit the most seriously ill patients.

DEVELOPMENT OF THE PROGRAM

The work has developed in many directions. For one thing, doctors feel that in this type of disease, it is as important for them to know about the general affairs of their patients, as it is to know about their hearts. Hence, one duty of the nurses is to inform doctors of conditions under which their patients live, and to what extent medical advice is being carried out. They also visit patients who are apt to be neglectful in attending clinics. These patients must be impressed with the vital importance of regular attendance at clinic.

Every child who has had rheumatism, no matter how mild the manifestations, is regarded as a potential subject of heart disease. The nurses teach the parents of these children the importance of frequent examinations and the removal of focal infection. They also urge rest in bed during the active stage of the disease, and advise a long period of convalescence. During convalescence the nurses find much can be accomplished through occupational therapy. Such service helps to keep the emotional, restless, young invalid quiet through interesting him in creative work, playing a game, or studying. This is educational and constructive. It is also a means of giving carefully supervised and gradually increased exercise as ordered by the physician.

Occupational therapy has also proved valuable for adult patients. This is especially true where the activities of the patient have been considerably restricted. Mr. Kay, for instance, afflicted with coronary heart disease, and no longer allowed to do his usual chores about the house, said, "Well, I might just as well be dead as to be so useless. I get tired of reading, and I worry about the things that aren't taken care of that I should be doing." Since the occupational therapist taught him wood carving, he is happily engaged in making shelves which when sold provide him with pocket money. Thus engaged, he no longer thinks of the heavy work which others of the family are quite able to do. His physical condition is much improved. No edema or dyspnea are apparent, and his pulse rate remains slow.

CHARACTER OF THE HOME SERVICE OFFERED

The nursing care given Mr. Kay is comparable to the service given other patients, and indicates functions of the cardiac service. The nurse takes his

heart rate with a stethoscope since it is irregular and the finer beats cannot be felt at the wrist. When his heart rate goes below sixty, she reports to the doctor, who temporarily reduces the dosage of digitalis. On the other hand, should the rate go above ninety, the doctor would increase the digitalis dose for a time. Thus the patient is spared the exertion of frequent clinic visits. In the case of Mr. Kay, walking out of doors in cold weather is almost impossible. Transportation to clinic can be secured for such patients when necessary. However, the expense and effort involved make frequent trips inadvisable.

Cardiac patients are inclined to be depressed. Therefore, when someone takes an active interest in them, they are encouraged to follow expert advice. Most of them coöperate well. These patients need assurance and encouragement, but at the same time the nurse must use discretion lest they undertake too much. Each person needs careful consideration pertaining to such individual problems as capacity for exercise, degree of anxiety about himself, and other worries.

Nutrition is another factor in cardiac care requiring observation and advice. Sometimes the doctor orders a high caloric diet; sometimes the order is for a salt-free diet, restricted fluids, or obesity diet, but in each case home instruction by the nurse is important. In the care of the child also, diet plays an important part, since body nutrition must be forced. It has been found in the examination of school children, that a much higher percentage of those classified as undernourished have heart disease, than do children who are properly nourished.

In order to avoid too much physical activity on the part of the patient, various adjustments have to be made in the home. In these cases it may be necessary to move to a ground floor home to avoid stairs. It would not be advisable for the patient to live on a steep hill if his limitations are curbed to a considerable degree. Other adjustments sometimes made are limitation of the home, school, or factory duties of the patient, a supplementing of the family income, or arrangements for vocational guidance and retraining.

Three years have passed since the cardiac service was inaugurated, and it is now an accepted part of visiting nurse work in Minneapolis. The value of preventive work is hard to prove in as much as results cannot be shown in figures. Nevertheless it may safely be stated that the service has meant prevention of heart disease through securing medical examination for potential cases, and early medical treatment for beginning cases.

The actual money saved through caring for some patients in their home under this plan is important. Many of these patients would otherwise have been forced to enter a hospital at their own or public expense. Sometimes the patient not only has been able to remain at home, but also to continue work while receiving treatment—a big saving to both patient and community.

Public Health Nursing and the Modern Aspects of Tuberculosis *

By FANNIE ESHLEMAN, R.N.
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TUBERCULOSIS, although no longer the leading cause of death, still stands at the head of all mortality rates between the ages of eighteen and forty-five. After infancy, it is in early adult life that we find the peak of tuberculosis mortality. Economically, because of the age period in which it chiefly occurs, and because of the years of invalidism it causes, it is probably the most wasteful and costly of all diseases. We know that it is preventable, and that, in certain stages, it can be arrested. If, as Trudeau wrote, every man and woman in the United States were familiar with the manner in which tuberculosis is communicated and the simple measures necessary for their protection, they would demand effective legislation for its prevention and control, and we might expect an even greater diminution in the morbidity and mortality rates than has occurred within the last three or four decades.

The modern conceptions of tuberculosis are increasingly of interest to the public health nurse. It is my purpose to describe briefly some of the newer aspects of the problem as they appear in the experience of a tuberculosis dispensary, and as they concern the work of the nurse in the clinic and in the home. That the nurse should be aware of these fundamental considerations is of importance to her understanding of what she is trying to accomplish in tuberculosis, and of the best methods to achieve her ends. It is essential, furthermore, to her task of spreading and explaining new ideas as they become available for practical use.

Although the tubercle bacillus was isolated as long ago as 1882, and although earlier work had convinced some of the infectiousness of the disease, tuberculosis was for a long time not treated realistically as a contagious disease. At the time of Koch, efforts directed toward its control were concentrated mainly on the sick individual. The greatest interest was engaged in treatment and in the development of sanatoria. It was not until 1887 that the first statesman-like plan was conceived of coördinating all efforts applicable to the tuberculosis problem. The fundamental idea of the dispensary scheme as it originated at Edinburgh (1), was not to care for the patient only, but to protect the other members of the family from further infection by segregating known cases of tuberculosis—the sources of contagion—in appropriate institutions. That tuberculosis should be reportable, like other contagious diseases was long advocated, and after some years compulsory notification of the public health authorities of every case diagnosed was adopted in Edinburgh. These measures embodied familiar principles of public health, but they have usually not been carried out consistently and thoroughly with regard to tuberculosis.

The plan of making the dispensary the center of community activity against tuberculosis has spread and has been further developed within the present century. At first the usual methods of examination were employed in the clinic and a diagnosis was in most instances established after impairment of the patient's health had begun, and frequently after it was considerably advanced. Often meager laboratory facilities would not permit the frequent examination of specimens of sputum, which are a valuable guide to physician and nurse

*This paper was read at the Annual Meeting of the Pennsylvania Tuberculosis Society, in Harrisburg, January 23, 1934.

in their prophylactic care of those exposed to tubercle bacilli. Patients who were diagnosed as having clinical disease were in many instances recommended to the regimen of a hospital or sanatorium. In most communities, however, hospital beds were, and still are, insufficient to meet the need of those requiring bed care. Admission lists for entrance to state sanatoria then, as now, were long. Patients still have to wait from six to twelve months before a vacancy occurs. Meanwhile they remain at home spreading tubercle bacilli and becoming a more dangerous source of infection as their disease progresses. Compulsory notification of the disease was early adopted in the United States, and more and more have public health nurses been employed to work in the clinic and to visit in the home.

WORK ON A HOUSEHOLD BASIS

The follow-up or nursing service was influenced in the past to a large extent by the type of medical work done. In very few instances was it planned on a household basis; that is, rarely was the household considered as a unit from the medical, nursing and recording points of view. As a rule one doctor examined the father, another the mother, a third two of the children, and perhaps a fourth physician saw the other children of the family. Medical and social records were frequently kept separately. Even though the nurse visited in the home the clinic physician was usually uninformed of the conditions she found, which nevertheless had a profound influence upon the health of his patient. The patient ill with tuberculosis was the first and often the only concern of the nurse. Even when she did try to see that the contacts were examined and supervised, this service was extremely difficult when three or four physicians were giving orders to one household, while its members as a group were trying to adjust themselves to the fact that tuberculosis existed among them. Again, frequent home visits may have been made, and very definite instructions may have been given for the care of the various members of the family. But how diligent were the efforts of the nurse to find the patient's source of infection and to trace the results of contagion? If a patient is suffering with typhoid fever every effort is made not only to provide adequate nursing care but to locate immediately the focus from which the disease is being spread. Interest in the epidemiology of tuberculosis is frequently not so acute as with other diseases, and many opportunities for tracing the source of infection are lost.

TRACING THE SOURCE

More recent dispensary experience reveals that one of the most pressing problems of public health today is still the finding of the patient with positive sputum, who, expelling tubercle bacilli, is a source of danger to others. With this as a starting point, the next step in the control of tuberculosis is to deal effectively with the results of contagion in those who have been living in contact with the source, by early discovery and adequate treatment. In clinical and epidemiological studies carried on for years at The Henry Phipps Institute it was found that (2):

(a) In families in which some member suffered or had suffered with tuberculosis with tubercle bacilli in the sputum, there were frequent and severe infections of other members of the household group, often developing into tuberculous disease.

(b) In families in which a member had clinical tuberculosis with no tubercle bacilli in the sputum, tuberculous infections were much less frequent and severe. It should be noted that there may have been some temporary elimination of bacilli before the period of observation began. A tuberculous patient with negative sputum is always a potential source of danger, and should have repeated examinations of the sputum to determine whether it has become positive.

(c) In families in which no member had clinical tuberculosis there was a much lower incidence of infection shown by the tuberculin test and X-ray. Most of the infections found in such "non-contact families" are acquired by casual contacts and are of no significance.

Nevertheless some severe infections are acquired by contagion occurring outside of the household group. In subsequent studies of school children it was pointed out that "It is possible that . . . spread of infection occurs in schools,

for here is the child's chief opportunity for intimate, regularly recurrent contact with others outside of his home." (3) However it is probably rare that a teacher, a pupil or an employe is attending school at a time when he or she is scattering tubercle bacilli. Surveys to find significant infections in school children are one means of discovering homes that contain a source of contagion.

Thus these studies support the view that tuberculosis characteristically originates through long-continued daily contact with an open, that is, a sputum-positive case, usually in the home, sometimes in the shop or school. They have shown, moreover, that tuberculous lesions implanted in adolescents by such contact commonly spread in the lung for a long time, often for years, without perceptibly impairing health (4). The lesion may become extensive and cavities may form without causing symptoms (5). It was demonstrated, also, that most of the tuberculosis of early adult life develops from these lesions of adolescence (2). Early and sufficient treatment to arrest them permanently will prevent the development of the disease. In general, the earlier the stage of the lesion, the more readily it will yield to treatment, and the shorter and less costly treatment will be. It was therefore concluded that "known contagion, centering about a diagnosed case of sputum-positive tuberculosis, is the most economic starting point for discovering tuberculosis in its most tractable phase." (6)

INTENSITY OF CONTAGION AND RESULTING INFECTIONS

It has been established experimentally that there is a relationship between the intensity of contagion and the severity of resulting infections. By the intensity of contagion is meant the frequency and the size of the "doses" of tubercle bacilli received by the "contacts" from the infecting source. This is determined by the quantity of tubercle bacilli expelled and the length and intimacy of the exposure. To a considerable extent this relationship may be modified by the susceptibility or resistance of the person exposed. For example, between the age of infancy and twelve or fourteen years tuberculous lesions tend to be benign, at least in white children, although even at this age period resistance can be overcome by large and frequent "doses" of tubercle bacilli. The connection is more evident in infancy. It is well known that mortality from tuberculosis reaches a high peak within the first two years of life, as was shown by Cobbett's figures in 1917 (7). More recently, clinical studies conclude that "in any infant the occurrence of a strong tuberculin reaction alone is warning and indication enough to do everything possible to prevent a fatal outcome" (8), and "even a weak tuberculin reaction may signalize a dangerous infection" (6). On the other hand, it was found that "even large pulmonary infiltrations in infants do not necessarily end fatally," as some have thought, and that "the determining factor, even after consolidation is extensive, is a complete termination of exposure to the infecting source." These clinical observations point the fallacy of the opinion, which still "persists, that once infection with tubercle bacilli has occurred it is useless to try to prevent further infection" (6) (8).

It is clear from the studies that have been cited that the earliest discovery of tuberculosis can usually be made in the families of known cases of tuberculosis. Here the incipient case, with early symptoms, will be discovered in the contacts, and lesions will be detected before they have caused symptoms. In dispensary experience the most practical attack upon tuberculosis of childhood and adolescence, and the most fruitful method of preventing the development of tuberculosis in early adult life, consists of thorough, periodic examinations of those who are living or have lived in family contact with sputum-positive tuberculosis (6). Medical and nursing supervision of the entire household is begun as soon as it is discovered that one member has tuberculosis. All the members are given, as promptly as possible, physical and X-ray examinations, with the tuberculin test, and sputum ex-

aminations. The medical examinations of contacts, including the tuberculin test and X-ray, are repeated annually or more often, the interval being determined by the length and intensity of the exposure, the age of the individual, and the appearance and course of any lesions that may be found (8). Arrangements are made for the care of those ill with the disease in hospital or sanatorium, and medical and nursing supervision are given to the patient as long as he remains at home. Supervision of the family may continue for years, to arrest in them the results of contagion, and to prevent further spread of contagion among them.

ONE PHYSICIAN FOR THE WHOLE FAMILY

This is the medical program on which the follow-up nursing service has been based (9). The part of the public health nurse in this scheme for the control of tuberculosis may be inferred from what has been said of the nature of the problem. For her work to be effective, it is necessary that one physician should see all the members of one household, and that he should interpret to them very simply and explicitly the results of their examinations and the medical recommendations. This is the foundation on which the nurse begins her work of nursing care and health education in the home. A close coöperative relationship can be established between the physician and nurse and the family only when one physician and one nurse are continuously responsible for the same household. This relationship, because of the chronicity of the disease, should usually continue for years. It is the duty of the nurse, moreover, to establish coöperative relations for the family with other medical institutions, and with social welfare and other agencies when needed.

A large part of her task, as has been implied, will be to seek for information needed by the physician, and to see that his instructions are carried out. She will develop great skill in questioning, and in eliciting information by various means. She must be thoroughly acquainted with the symptoms of tuberculosis (10) and she will look out for them, training herself to observe and to record the most inconspicuous. She will understand, and be able to teach, the strict personal hygiene by which alone contagion can be prevented while the patient is living in the house. She will help plan the family budget to include adequate diet, and to maintain good living conditions, which are essential in the care and prevention of tuberculosis. She will supervise the entire family, especially those contacts for whom medical recommendations have been made. She will give nursing care to the patient ill with tuberculosis, seeing that he has a separate bed, and if possible a room to himself. She will observe and record his symptoms with the minutest accuracy. She will know how to make him comfortable, how to explain what rest means in the treatment of tuberculosis, and how to persuade him to submit to a tedious routine.

REST THE PRIME ESSENTIAL

In the treatment of tuberculosis, as at present understood, rest is the prime essential. At one time climate was thought to be of the first importance, or diet, or even certain kinds of exercise. It is now known that tuberculosis can be arrested in any climate, and that fresh air, though valuable, is only secondary in treatment. Food should be ample, but excessive and eccentric diets are no longer advocated. Dispensary experience has long shown that racial and national preferences need not, and should not, be violently disturbed (11) (12). It is usually desirable to add a reasonable amount of milk to the diet of the patient until his weight has increased slightly beyond his normal (10), and to give extra milk to the children of his family. But modern practice depends upon rest to check the tuberculous process.

DURATION OF TREATMENT

One of the most important aspects of the treatment of tuberculosis is that it should be continued long enough to ensure that a permanent arrest has been secured. Many observations have shown that symptoms and physical

signs commonly disappear early under treatment, while the lesion that caused them continues to spread, or will begin to spread again under the conditions of normal life. If the patient is allowed out of bed too soon, if perhaps he is permitted to return to his home and his work, relapses will follow after varying intervals, during which he may scatter tubercle bacilli afresh (8). Moreover, especially of adolescents it is said that "their splendid capacity for repair, even of rapidly spreading lesions, is balanced by a tendency to disastrous relapse" if treatment is too short (5). Not only should treatment in tuberculosis be continued until the lesion has ceased to progress, but until it has retrogressed to a stage that will remain unchanged under reasonable living conditions, as can be shown in X-ray films. Both physician and nurse will often find it extremely difficult to persuade patients to submit long enough to treatment, especially children and adolescents who feel well.

LOCAL REST THROUGH SURGERY

The nurse will be interested in the various surgical methods, which are coming more and more into widespread use, by which local rest is applied immediately to the diseased lung. Within the past few years surgical intervention has been applied to suitable cases through the dispensary at the Phipps Institute (13). Patients have been sent for one or two weeks to local hospitals in which beds could be obtained for this purpose. Here artificial pneumothorax is instituted; that is, the lung is collapsed by introducing air into the pleural cavity. Thereafter the patient remains at home, coming to the clinic for "re-fills." In the intervals he may stay in bed, but in most cases he is soon ambulatory, since the lung itself is immobilized.

This plan offers one solution, through the dispensary, to the problem of some of those patients who must remain at home because of a lack of beds. On the one hand, many such patients would die before their turn comes to be admitted; on the other hand, a considerable percentage of the patients who were given this treatment, were back at work before they received their sanatorium call. This treatment is particularly desirable for colored patients (14) who are especially unsuited to long delays, because in them tuberculosis characteristically progresses more rapidly, and more often to a fatal end than in white patients.

For patients given artificial pneumothorax in the clinic a regimen of rest in bed at home may be prescribed, similar to sanatorium care in like cases. This is continued until in the opinion of the physician the patient can safely assume the activities of normal life. It may be recommended for a week or two or for several months, depending upon the condition of the other lung when both are affected and only one is collapsed or partially collapsed, and upon other indications. It is noteworthy that when only one lung is diseased positive sputum usually becomes negative shortly after a successful collapse, and the patient is no longer a source of contagion to his family. In her follow-up work the nurse must be aware of what medical recommendations have been made and of the reasons for them. In her contacts with the patient, she should impress upon him the importance of taking the rest advised by the physician. She should further urge strict adherence to the schedule of visits to the clinic for "re-fills." Haphazard visits may result in the formation of adhesions and loss of the pleural space into which air is injected, rendering treatment difficult and in some cases impossible.

SUMMARY

Thus one plan for the control of the disease that has evolved out of the modern aspects of tuberculosis, may be summed up as a public health problem in the following terms: to deal with tuberculosis as a contagious disease, originating and spreading mainly within family groups. The goals sought are to find the sources of contagion that exist in the community, to prevent the further spread of contagion, and the fur-

ther development of the infections that have been caused by contact with these sources. In these families it has been found possible to establish the early discovery of tuberculosis in its widest sense. The method by which these ends may be attained consists of periodic examinations of the tuberculous and their immediate households, with medical and nursing supervision, often carried out for years. Medical observations have been cited that support these views.

The public health nurse is concerned with the necessity and with the difficulty of treating tuberculosis realistically as a contagious disease. The facts are just as real as with typhoid fever or any other infectious disease, but they are so much less dramatic that they may escape notice. To stop contagion is just as important with the one as with the other, but in tuberculosis it may be more difficult, because small considerations, trifling and tedious routines, are involved over long periods of time.

It is the duty of the nurse to seek for the source of contagion in the household. This may be the patient who has first attracted attention; it may be some other member of the family with a slight habitual cough; several sources of contagion may have developed within the household before it was noticed.

It is the nurse's duty to look for the results of contagion, seeing that the contacts are given medical examinations, persuading them to accept medical advice, and looking out sharply herself for early or inconspicuous symptoms.

While the patient is at home, she must see that the equivalent of sanatorium care is carried out. She must see that the strictest hygiene is maintained to stop completely all further spread of contagion within the household. She must know the value and the meaning of rest in the treatment of tuberculosis. This may be general rest in bed, or local rest, induced by surgery. By her expert advice, she will help the family to maintain the good living conditions necessary in treatment and prevention. She will be indispensable as a liaison officer between the family and the medical and social agencies concerned in their care.

The public health nurse should be an invaluable aid to the physician in the discovery, care and prevention of tuberculosis. For these tasks she will constantly require tact and patience, unflagging interest, wide understanding, and eternal vigilance.

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The Supervisor as Seen by the Staff Nurse

By IVAL WILKINS, R.N.
Staff Nurse, Metropolitan Life Insurance Company

I HAVE spent nigh onto fifteen years as a staff member of a public health nursing association and it seems to me I ought to be able to present opinions of some value concerning supervision and supervisors. Whether or not I can express those opinions decisively, tactfully, or constructively is something else again, but in the event that I do not, I mean well anyway!

What staff nurses expect of supervisors might seem to many (especially to staff nurses) a subject worthy of thoughtful consideration but, as a matter of fact, most staff nurses learn in time not to actually expect anything very definite or specific of supervisors; they learn to take them as they come (without comment, if they are wise) and claim the privilege of mentally placing them in one of three classes, good, bad, or average. For supervisors are not all of the same stamp; they are like every other large group of workers in that most of them are average, some are very good, and a few are really poor. The staff nurse who is not able to appreciate really good supervision should be dismissed without any loss of time; without any monkey-business. She may be of some value to the community but is a detrimental influence upon other nurses, giving rise to unwholesome gossip, petty grievances, and a general attitude of resentment. Occasionally, however, the staff nurse who dares to express opinions which differ from those of her supervisor or other executives is automatically branded as one who resents supervision. Thus that excellent quality, initiative, is sometimes discouraged and the nurse of rare calibre may become quite commonplace. This is of more significance at present when actual fear of unemployment is so prevalent. The ideal supervisor is not one to make this mistake. She realizes that the nurse who is capable of individual mental activity is infinitely more valuable than one who lives her whole life by ready-made rule and second-hand opinion. The staff nurse who has not learned that every supervisor is of some value is unfortunate; she is cheating herself and does not know it.

The A-1 staff nurse—the staff nurse of good judgment and excellent emotional control—(and she, like the ideal supervisor, is not of the majority) will never be greatly disturbed by a really poor supervisor. She will be as pleasant and as agreeable as is necessary to avoid friction but will, when possible, follow the dictates of her own mind and conscience with regard to the more important phases of her work.

The average staff nurse, the staff nurse of less strength of will and reason, may not get on so well with a really poor supervisor, while the really poor staff nurse may seem in good standing. It is difficult, if not impossible, to explain this latter situation but the old-time adage about birds of a feather suggests an explanation. The average staff nurse will probably regard the average supervisor as a good scout or, to put it in typical American style, a good egg, one of the gang. She has the same respect for the opinions and ideas of such a supervisor as for her own opinions but no more. This of course may not be true of staff nurses too recently introduced to public health nursing to have developed opinions of their own or of those who, for reasons less credible, never develop opinions of their own. The work, under the direction of such a supervisor, may be carried on very smoothly in an atmosphere of happy coöperation and understanding unless the supervisor assumes an authoritative attitude not in keeping with her ability, or the staff nurses take advantage of the fact that her limitations deny the justification of much authority.

But whether or not there is any or much harmony, there can be no great progress for the individual staff nurse or the service in general without good supervision. Although it is true that the poorest supervisor often teaches valuable lessons, consciously or unconsciously, the good she does is not to be compared with that of the ideal supervisor. A supervisor may promote or retard, by her influence upon the staff nurse, the progress of any nursing service under her jurisdiction.

The ideal supervisor always promotes progress; she stimulates her nurses to enthusiastic action by making them feel her interest in them and in the result of their efforts; making them feel absolutely certain of her moral support. She calls forth the best that is in them by placing unreserved confidence in their integrity and ability, emphasizing their strong points (if any) and mentioning their weaknesses only as necessary. The ideal supervisor does not quibble over unimportant detail while commendable achievements pass unnoticed. She has, however, the courage to deal firmly with staff nurses when occasion warrants such action. She never reproves or corrects a nurse in the presence of any other person nor does she discuss one nurse with another. The ideal supervisor is never influenced by second-hand information concerning her nurses; she knows all of them first-hand and impartially. She is chummy with none, yet knows each one personally as well as professionally, for often the cause of poor work or other undesirable traits may be found in a nurse's home life or in the use of her leisure time. The ideal supervisor knows the community or communities in which her nurses work; the doctors, the people, their habits and customs, their wants and how to help them. And although she teaches all this and much more, as the nurses need instruction and guidance, she is ever of a receptive mind; never resents suggestion. The ideal supervisor is not perfect; if she were she would not be ideal. She sometimes makes mistakes and at times, when it is best to do so, will admirably admit her own errors. The ideal supervisor is thoroughly trained, practically and theoretically. Her education is general and of high degree, but with it all she has much common sense; a knowledge of life and things and people that no amount of schooling can teach; a sympathetic and applicable appreciation of human psychology; a fine sense of justice and a keen sense of humor. Quite naturally the ideal supervisor commands respect; she need not demand it. She is respected because of her ability; she is loved because of her sympathy and understanding. Her influence will live forever though her name like her person may at last fade into nothingness.

TICK BITE FEVER

Tick bite fever can be contracted either through the bite of an infected tick or by absorbing the infectious material through a break in the skin. The infectious material from crushed ticks will stick to the hands and may also be accidentally rubbed into the eyes, or may find its way to the mouth or nose. Fortunately not all ticks are infected, but it is better to regard them all as sources of danger and to act accordingly. Here are some of the things that should be done:

1. Avoid ticks and tick-infected areas.
2. Remove any ticks you find on your person as quickly as possible but take care not to break or crush them. After removing ticks, wash the hands thoroughly with soap and water. Take the same precautions in removing ticks from animals.
3. Cut out undergrowth and weeds. Cut grass very short along paths, near bathing pools and shores.
4. If your work or pleasure takes you through tick-infested areas, go over your body and your clothing carefully, for ticks, when you return home.

Bulletin, Maryland State Department of Health.

Extended Leadership Through State Advisory Nurses

THAT there is fresh leadership in public health nursing was proved by the all day conference of State advisory nurses called by the National Organization for Public Health Nursing on April 28, 1934, following the Biennial Convention in Washington. The United States Public Health Service made available its new auditorium for the meeting and Miss Pearl McIver, recently appointed Associate Public Health Nursing Analyst of the Service, presided.

From coast to coast, from north to south, the country was widely represented, including the nursing services of twenty-two State health departments; the Health Department of the District of Columbia; two State departments of education; the Provincial Health Department of Ontario, Canada; the Office of Indian Affairs, U. S. Department of the Interior; the United States Public Health Service; and the N.O.P.H.N.

THE UNITED STATES PUBLIC HEALTH SERVICE

Dr. C. E. Waller, Assistant Surgeon General in charge of the Division of Domestic Quarantine of the United States Public Health Service, welcomed the group and announced that the Public Health Service is now prepared, through Miss McIver, to give advisory nursing service to the State Health Departments. He reviewed the historical development of the Public Health Service from its initial function in providing medical care for seamen in the American Merchant Marine and protection of the country against threats of cholera and plague; through its national quarantine service, to the present program which also includes sanitary control of water supplies and shellfish, prevention of epidemic diseases, assistance in state health surveys, the development and maintenance of county health units and scientific research. In reality the present Division of Domestic Quarantine now functions as a "Division of States Relations."

PERSONNEL PRACTICES IN OFFICIAL AGENCIES

Miss Sophie C. Nelson emphasized the importance of developing standards relating to personnel practices in official agencies. This was a particularly timely topic due to the trend toward increased employment of nurses by official agencies. It involves a study of qualifications; methods of employing those qualified and of eliminating those who are not; staff education; salaries; vacations; hours of work, etc. It includes review of the whole question of civil service, the need to have interested people serve on civil service commissions and the need for stimulation of a well-informed citizens' group to back up civil service and public health nursing.*

Miss Tucker described the plans of the N.O.P.H.N. Committee on Personnel Practices in Official Agencies for a study to be undertaken in the fall of 1934 covering the points mentioned by Miss Nelson and asked the assistance of the State advisory nurses in carrying them out.

Among those states represented at the meeting, four reported that their nursing services were under State Civil Service and thirteen have qualifications defined by rules or statutes.

The consensus of opinion of the group was that:

1. Civil Service is a protection if standards are sufficiently high and at the same time elastic. Therefore, states not having it, might well be encouraged to seek it with proper safeguards.
2. The steps toward getting civil service might be
   a. Defining public health nursing in each state.
   b. Setting up properly high qualifications.
   c. Acceptance of desired qualifications by a representative lay group, as

*See also Mr. Lansdale's article in this number, page 403.

well as by a committee of nurses, before beginning to work for legislation.

3. Some plan is needed for getting desirable personnel standards into actual practice in official agencies. This will also improve the standards of non-official agencies.

SUPERVISION AND STAFF EDUCATION

District group meetings of one day each as carried out in Virginia were described by Miss Mary Mastin, Director of the Bureau of Public Health Nursing. The purposes were economy, substitution for individual field visits from State advisory nurses and group discussion. There are six districts in which quarterly meetings are held. Local nurses are in turn hostesses. The two assistant directors of nursing select the subjects for study, assign topics to the nurses and prepare reference material. In addition to discussion by the nurses themselves, there is also one outside speaker. Where appropriate, visits to local institutions are made.

The subjects covered so far have been nutrition, tuberculosis, the preschool child and the summer round-up. In the last, members of the Parent-Teachers Association have taken part and the laymen's point of view has been brought into the discussion.

This plan has proved a stimulus to the nurse and has made a new contact between the nurse and her field advisor resulting in increased requests for field advisory service.

In discussion: Miss Marion Sheahan of New York described the extension course given jointly for the past five years by the New York State Health Department and New York University as an effective staff educational device. The nurses throughout the state meet in groups of twenty-five to fifty for two hours, once a month, from October to June. The subjects are selected on the basis of the nurses' own suggestions, the State Health Department supervisors act as teachers, group leaders are selected and given a week's preliminary instruction and considerable prescribed reading and study is required and a final examination is given. So successful has this course been that other states are copying it.

RECORDS AND REPORTS

Miss Olivia T. Peterson, Superintendent of Public Health Nursing in the State Department of Minnesota, exhibited and discussed a number of record and report forms used to stimulate local nurses. A summary of the annual report of each county nurse is prepared showing the total amount of service for the current year compared with the previous year or years and also compared with standards set up in the Appraisal Form of the American Public Health Association.

Another device is a chart, made up in standard size for each nurse, showing the correction of defects among school children in the first and sixth grades. The comparison is considered a help to the nurse in evaluating her own work.

An exhibit is also prepared of the work of some outstandingly successful nurse, and is shown to other nurses throughout the state.

Each nurse carries a "Family Case Record Notebook" in loose-leaf form containing, in addition to the family record, "Township Index" listing the schools, teachers, and names of the nursing committee members. In Minnesota, it is required by statute that every school child have a health record card and the form is approved by the State Boards of Education, Control, and Health.

An especially satisfactory device is a summary report sent to each local superintendent of schools after the first and subsequent visits of the nurse to the local schools.

Miss Peterson concluded that there is little essential difference between records and reports for rura. and city health work and that the same general scheme can be used in either type of service.

PUBLIC HEALTH NURSING SERVICE AND STATE HEALTH DEPARTMENT

Miss Katharine Tucker, general Director of the N.O.P.H.N., discussed the question of relationships under two headings:*

*See also Miss Tucker's presentation of this topic in July, 1932, PUBLIC HEALTH NURSING

1. *The relationship to other services within a health department.*

It is a generally accepted principle that public health nursing in a State health department be administered as a unit, headed up by a well qualified public health nurse. Where it is placed or what it is called does not make so much difference.

The relationship of the Department of Public Health Nursing should be close to all other units which are carrying on programs promoted through public health nursing. It is therefore important that whenever these programs are being discussed a public health nursing representative be included in the planning and that decisions regarding them be reached jointly.

2. *The relation of the state public health nursing personnel to local services.*

The local health officer is recognized as the administrative head of the local health department. The State health department representatives are concerned with health service for the state as a whole and attempt to develop good standards of public health nursing in all services within the state.

The state public health nurses should work through the local health officers in promoting the standards of public health nursing in the local services. Therefore the state nurse's contact is through the local health administrator and it is important for the state nurse to notify the local health officer of contemplated visits and to call on him when in his territory.

The relationship to local nurses:

A. Where state funds support the local service the relationship is direct.
B. Where there are both local and state funds the relationship is advisory.
C. Where a local service is supported chiefly by private funds the relationship is also advisory.

In the case of "A" and "B" above the State Health Department can set up qualifications of nurses employed in the local area and require that they be met.

In all relationships of the state nurse to the actual job of the local nurse it is well to put emphasis on the advisory rather than the supervisory nature of the service. The state nurse studies the local situation to make immediate emphasis which will help the local public health nurses to do a better job in that locality in terms of state standards.

In discussion: It was reported that 15 of the states represented have their public health nursing services organized under one unit. The importance of having a separate budget for the public health nursing unit was emphasized.

The use of itinerant field units—a plan for field advisory service by a team representing the four types of personnel in a county health unit, the health officer, public health nurse, sanitarian and clerical assistant—was discussed by nurses from Alabama, Tennessee and Mississippi, each emphasizing that the value of this plan lies in the integration of points of view made possible in group action.

RELATIONSHIP OF PUBLIC HEALTH NURSING AGENCIES TO THE MEDICAL PROFESSION

Dr. Estella Ford Warner, Surgeon, United States Public Health Service, stressed three approaches for improving the relationships of public health nursing to the medical profession: the medical profession, the public health nurse, and the community.

As changes in the form of medical practice occur there may be a broader application of public health service. It is essential that the local physicians be in touch and in sympathy with local public health nursing service.*

For the nursing service, the essentials are that the nurses themselves follow ethical procedure, that the doctors be used as advisors and that every nursing service have an organized medical advisory committee, that the nursing agency have definite plans of what it wants to do and how to do it and that these be presented to the medical advisory committee before they are undertaken.

The community, as represented by the lay public, is the most effective agent in developing the standards of medical and nursing service which it wants and can increasingly influence the future situation.

In discussion: Some of the means of stimulating good relationship reported on by the state nurses were:

1. A public health nursing committee of the State medical society working with the State health department and with the State organization for public health nursing (this committee sent suggested "standing orders" to every local public health nursing service in the state).

2. A public relations committee of each

*This magazine is publishing a comprehensive article on this subject in an early Fall number.

county medical society working with local nursing services.

3. Distribution of the "Objectives in Public Health Nursing" and "Minimum Qualifications for Those Appointed to Positions in Public Health Nursing" to state and county medical societies.

4. Routine contact of State advisory nurses with county medical societies when on field trips.

5. Encouragement of local nurses to contact local medical societies, giving demonstrations of prenatal visits, communicable disease care, etc. Debates on generalized versus specialized nursing have also been given before medical groups.

WHAT WE HAVE LEARNED FROM CIVIL WORKS AND RELIEF PROGRAMS

Miss Alma C. Haupt, Associate Director of the N.O.P.H.N., spoke of the two aspects of the federal relief program which have affected public health nursing. Rules and Regulations No. 7 of the F.E.R.A. which provided for bedside care to families of the unemployed in their own homes who are on relief, and C.W.A. Rulings No. 7 made nursing care a legitimate claim on public relief and has permitted the buying of service on the cost per visit basis from private agencies where no public agencies give bedside care. It has also emphasized the use of existing agencies rather than the setting up of new or duplicating services.

The Civil Works Program temporarily overshadowed Rules and Regulations No. 7. It is estimated that 6,000 unemployed nurses were used in Civil Works projects. Considerably more than one-half of these were assigned to public health duties although many of them had never had public health training or experience. In over forty states there have been state nursing advisory committees working closely with state relief associations, the American Nurses Association, and the National Organization for Public Health Nursing.

The results of the Civil Works program were briefly summarized as

1. A new opportunity to bring before the public the meaning of skilled nursing and the differentiation between private duty, institutional and public health nursing.

2. Appreciation of the need for understanding of qualifications in public health nursing.

3. Emphasis on the importance of supervision to insure good work and to develop the field nurses.

4. Experimentation with new methods of staff education particularly for rural nurses and the preparation of simplified manuals and record forms.

5. The selection of projects in relation to the needs of the community and the ability and preparation of the nurses for the projects.

6. A wider distribution of public health nursing service.

7. Expansion of programs, especially in maternity and child health service, bedside nursing, and communicable disease control.

8. The development of new services and efforts to organize permanent new agencies in some localities where such agencies had not previously existed.

It was the consensus of opinion of the group that the States might look forward to the continuation of some form of work relief for unemployed nurses and that Rules and Regulations No. 7 should be emphasized again. Already nine of the States represented had received new orders from the "Work Division" of the F.E.R.A. to use unemployed nurses.

The group urged that the A.N.A. and N.O.P.H.N. write again to state nursing groups encouraging the continuance of state nursing committees on relief and urging that such committees have representation from the State nurses associations, the public health nursing group and the lay public, and that these committees keep in touch with state relief administrators in the development of plans involving nursing.

It was also suggested that when C.W.S. nurses do not meet State health department qualifications and have been permanently employed by the locality, such nurses be encouraged to qualify within a specified period.

Miss Sheahan reported that a questionnaire to State health departments regarding nursing services is being prepared as a joint project of the N.O.P.H.N. and the Public Health Nursing Section of the American Public Health Association. The questionnaire was read and suggestions were made regarding it.

Nurse-of-the-Month

GLADYS BLASLAND
New Hampshire

I grew up in the shadow of the White Mountains. The folk tales I heard from my mother and father stimulated my imagination and my love for this whole north country. My mother was a good neighbor to the people of our community, and she did a great deal of voluntary nursing and social service work. This unquestionably directed my desire to take up nursing as a profession. I received my nursing education at the Children's Hospital of Maine, and had a postgraduate course at the Corey Hill Hospital of Boston. I did hospital work in Massachusetts, industrial nursing with the Brown Paper Company at Berlin, New Hampshire, district nursing in Winchester, Massachusetts, and then returned to private duty in the towns of northern New Hampshire.

About this time I met at a child health conference the Director of the Maternity, Infancy and Child Hygiene Division of the New Hampshire State Board of Health. I talked with her about a public health position on her staff. She advised me to take a course at Maternity Center Association in New York and in 1926 I took the Maternity Center course and immediately afterward joined the New Hampshire State Board of Health nursing staff. My territory was to be Coos County, the northernmost in the State.

The work of this Division is carried on under a State Director who is also State Supervising Nurse. The activities are home visits to mothers, babies and children, first visits to all cases of tuberculosis reported by physicians, the organization of maternity, child health, dental and immunization clinics, group teaching and consultation service to other public health nursing agencies. In every town we have a child health committee which represents the local group interested in the health, welfare and education of children. All the regular and special activities are put on with their help. They take care of arrangements, publicity, transportation, assist the mothers at the clinics, and many do splendid follow-up work. These local committees create a community responsibility to the children and to the work, and they are a real help to a busy nurse. They relieve her of the routine work and leave her more time for the professional aspects of her program.

This public health service means a great deal to the people of this district. I have watched their attitude change from one of skepticism to one of confidence and health-consciousness. Sometime ago one of the local nurses in a most isolated section of the district said to me: "My people used to read the Almanac, now they read the Board of Health literature."

Many of the small towns are without medical or nursing service, and until two years ago the hospital facilities for the very northern part were most inadequate. Recently a new county hospital

has been built. Our maternity clinic in Berlin is one of the best attended in the State. With the snow piled up as it has been this past winter and the thermometer down to 35 and 40 below zero, it hasn't been easy to get mothers to and from the clinic. I hire a trustworthy man to do the driving, and those needing transportation (and many do) are sent for.

In addition to my working equipment I carry in winter a shovel, snowshoes, paper, wood, matches, gun and usually a lunch. My days are long and in the winter the traveling on these hills is dangerous. I start out with a carefully planned day's schedule which is upset if I land in a snowpile or ditch, or if the car skids and turns over. Getting out of the ditch, traveling into the woods on snowshoes to find a family, driving sixty miles over an icy road or in a mountain snowstorm to see a sick baby, building a fire and sitting by the side of the road until someone comes along to help if you are in difficulties are all part of the day's work and make life more adventuresome.

We all help each other; it is "the law of the road" in this country. If things get too hard and we keep our eyes too close to earth, all we have to do is look up. Summer or winter the beauty of the mountains is sublime. We may not have the staff or facilities which are thought necessary to an adequate program, but one must be satisfied with signs of progress, and they are apparent in this State. Mothers and children are being better cared for with each succeeding year; they are becoming more important as a social group, and with the continued activity of this Division and the coöperation of the other health agencies of this County they will be better cared for in the time to come.

COMMENT ON A QUESTION IN THE QUESTION BOX

Brookline, Mass., May 14, 1934.

I have been reading with interest the questions and answers given in the Question Box each month and I feel moved to discuss the presentation of questions that are of vital interest to any public health program.

In the May issue appeared the question "If only one visit can be made to a preschool child between the ages of one and six years, when should the public health nurse visit and what should she teach?"

This would seem to me to imply doing something that, if it were analyzed, is not only impossible but suggests that a poor substitute is better than nothing. No matter how good a visit the nurse makes or how intelligent the mother may be, it would not be possible to compass in one visit the instruction that would be needed to guide the parent over a five-year period. If the visit is made the first year, it can be nothing but a steering lesson at its best and if left until the child has reached his fifth year, many of the health hazards that have a lasting effect on the adult life of the child have already been met.

Even if we assume that the child has been immunized against every possible disease before his first birthday (a supposition that would assume a Utopia that is still in the far future) there still remains so much health teaching that can only be effective during the preschool period, that successful teaching can only be possible with continuous contact during the period before the child is admitted to school.

The "Survey of Public Health Nursing" tells us that the public health nurse makes a poor showing as a teacher of health. We say she must be better prepared to teach. Both facts we accept. But the best prepared teacher would fail if presented with the task of doing a good job where she is expected to outline a child health program that is to cover five years of a child's life and get it over to the parent in one visit.

The time element in education is of paramount importance and without sufficient time it is impossible to do good work.

It would seem to me that the nurse who can make only one visit in five years to a preschool child should concentrate her efforts on some sort of a community program that would get her before the public where she might at least have the opportunity of presenting a well thought out and continuous child health program every year.

Elizabeth Ross, R.N., Director of the Health Center,
Brookline Friendly Society, Brookline, Massachusetts.

LIST OF BOARD AND COMMITTEE MEMBERS ATTENDING THE BIENNIAL CONVENTION

The following board and committee members registered at the Biennial Convention and attended the various meetings of the N.O.P.H.N. Board and Committee Members Section as well as other meetings:

COLORADO

Mrs. E. E. Nichols, President, Visiting Nurse Association, Colorado Springs.

CONNECTICUT

Miss Maude Clark, Chairman, Committee, Public Health Nursing Association, East Hampton.
Mrs. George W. Clements, Vice-President, Visiting Nurse Association, Stamford.
Mrs. D. S. Cruikshank, President, Visiting Nurse Association, Stamford.
Miss Amy Dana, Member, Visiting Nurse Association, New Haven.
Mrs. Waldo Grumman, Secretary, Visiting Nurse Association, Fairfield.
Mrs. Alfred Hammer, Chairman, Nursing Committee, Visiting Nurse Association, Branford.
Miss Elizabeth Hooker, Board Member, Visiting Nurse Association, New Haven.
Mrs. John McKeon, Board Member, Visiting Nurse Association, New Haven.
Miss Hilda Peck, President, Visiting Nurse Association, Bristol.
Mrs. Dutro Plumb, President, Visiting Nurse Association, Fairfield.
Miss Helen Porter, Board Member, Visiting Nurse Association, New Haven.
Mrs. C.-E. A. Winslow, President, Visiting Nurse Association, New Haven.

WASHINGTON, D. C.

Mrs. John W. Burke, Board Member, Instructive Visiting Nurse Society, Washington.
Mrs. S. Howland Chase, President, Instructive Visiting Nurse Society, Washington.
Mrs. C. B. Crawford, Board Member, Instructive Visiting Nurse Society, Washington.
Mrs. Whitman Cross, Honorary President, Instructive Visiting Nurse Society, Washington.
Mrs. C. C. Glover, Jr., Member, Instructive Visiting Nurse Society, Washington.
Janet B. Hautz, Third Vice-President, Instructive Visiting Nurse Society, Washington.
Mrs. Emory Laud, Board Member, Instructive Visiting Nurse Society, Washington.
Mrs. William B. Marbury, Board Member, Instructive Visiting Nurse Society, Washington.
Dr. Estella Ford Warner, United States Public Health Service, Washington, D. C.

ILLINOIS

Mrs. George E. Brown, Secretary, Public Health Nursing Association, Aurora.
Mrs. G. E. Huntoon, President, Public Health Nursing Association, Moline.
Mrs. P. R. Preston, Board Member, Visiting Nurse Association, Rock Island.

INDIANA

Mrs. Charles E. Bills, President, Public Health Nursing Association, Evansville.
Mrs. Henry B. Heywood, President, Visiting Nurse Association, Indianapolis.
Mrs. L. A. Guthrie, President, Visiting Nurse Association, Muncie.

KANSAS

Mrs. Walter H. Weidling, President, Public Health Nursing Association, Topeka.

KENTUCKY

Miss Lila Breed, Public Health Nursing Association, Louisville.

MARYLAND

Mrs. Alex. Murdock Norris, Visiting Nurse Association, Baltimore.

MASSACHUSETTS

Mrs. Louis Arnold, Treasurer, District Nurse Association, Newton.
Mrs. Thomas Blodgett, President, Visiting Nurse Association, Great Barrington.
Miss Harriet Clarke, Vice-President, District Nursing Association, Worcester.
Mrs. F. S. Dellenbaugh, Secretary, Community Health Association, Boston.
Mrs. A. R. Hussy, President, Community Nurse Association, Plymouth.
Mrs. Harold Marvin, President, Mass. State Organization for Public Health Nursing, Chestnut Hill.
Miss Gertrude Peabody, Vice-President, Community Health Association, Boston.
Mrs. J. H. Seaman, President, Community Nursing Association, Fair Haven.
Mrs. Frederick Turner, Secretary, Visiting Nurse Association, Great Barrington.

MICHIGAN

Mrs. George Bain, Member, Children's Fund, Dearborn.
Mrs. William Bohmier, Member, Children's Fund, Baroga County.
Mrs. J. E. Chapman, Member, Visiting Nurse Association, Dearborn.
Mrs. S. Homer Ferguson, Secretary, Visiting Nurse Association, Detroit.
Mrs. D. K. McEachern, Member, Children's Fund, Baroga County.
Anne Lawrence, Member, Children's Fund, Dearborn.
Ethyl Neelands, Member, Visiting Nurse Association, Dearborn.
Elma E. Nelson, Member, Children's Fund, Baroga County.
Josephine Polmka, Member, Children's Fund, Baroga County.
Mrs. S. W. Utley, Treasurer, Visiting Nurse Association, Detroit.
Mrs. James Walsh, Chairman, Publicity Committee, Visiting Nurse Association, Detroit.
Mrs. J. C. Watson, Member, Children's Fund, Ironwood.
Mrs. James Watkins, President, Visiting Nurse Association, Detroit.

MISSOURI

Mrs. George Carpenter, Jr., Chairman, Municipal Nurses Board, St. Louis.
Mrs. John M. Haskell, President, Visiting Nurse Association, St. Louis.

NEW HAMPSHIRE

Mrs. Charles B. Manning, President, District Nursing Association, Manchester.

NEW JERSEY

Mrs. Asher Atkinson, President, Visiting Nurse Association, New Brunswick.
Mrs. A. W. Brigham, Member, Visiting Nurse Association, Orange.
Mrs. Eugene Hatch, Vice-President, Visiting Nurse Association, Plainfield.
Mrs. George J. Holmes, President, Visiting Nurse Association, Newark.
Mrs. Landreth King, First Vice-President, Visiting Nurse Association, Orange.
Mrs. L. A. Morton, Member, Visiting Nurse Association, Orange.
Mrs. Robert Rushmore, Member, Visiting Nurse Association, Plainfield.
Mrs. Leonard Smith, Chairman, State Lay Section, Orange.
Mrs. Francis Stokes, Chairman, Education Committee, Visiting Nurse Association, Moorestown.
Mrs. S. Emlen Stokes, President, Visiting Nurse Association, Moorestown.
Mrs. George Swift, President, Visiting Nurse Association, Elizabeth.
Miss Katherine Wilson, Member, Visiting Nurse Association, Bayonne.

NEW YORK

Mrs. William Baker, Chairman, Nursing Committee, Public Health Nursing Association, Rochester.
Mrs. Charles R. Brown, Jr., Chairman, Nursing Committee, Henry Street Visiting Nurse Service, New York.
Mrs. Frances Carr, President, Public Health Nursing Association, Eastchester.
Mrs. D. N. Crouse, President, Visiting Nurse Association, Utica.
Mrs. H. S. Downing, Chairman, Visiting Nurse Committee, Millbrook.
Mrs. A. L. Goudvis, Chairman, Committee, Visiting Nurse Association, New Rochelle.
Mrs. Morris Hadley, Vice-Chairman, Henry Street Visiting Nurse Association, New York.
Mrs. M. K. Hart, Corresponding Secretary, Visiting Nurse Association, Utica.
Mrs. Shepard Krech, President, Maternity Center Association, New York.
Mrs. Mary Lambert, Member, Association of Junior Leagues of America, New York.
Mrs. Jean Smalback, Vice-President, North Shore Public Health Nursing Association, Flushing.
Mrs. S. C. Steinhardt, President, Visiting Nurse Association, New Rochelle.
Mrs. R. A. Stevenson, Chairman, Visiting Nurse Association, Yonkers.
Mrs. H. G. Stiles, Chairman, Nursing Committee, Visiting Nurse Association, New Rochelle.
Mrs. John M. Ward, Member, Public Health Nursing Association, Rochester.
Mrs. Homer Wickenden, Member, Public Health Nursing Association of Eastchester, Tuckahoe.

OHIO

Mrs. Tyler M. Carlisle, President, Maternity Hospital, Cleveland.
Miss Grace Frost, President, District Nurse Association, Toledo.

PENNSYLVANIA

Mrs. Charles S. Baker, Corresponding Secretary, Visiting Nurse Association, Lancaster.
Mrs. J. W. B. Bausman, Chairman, Education Committee, Visiting Nurse Association, Lancaster.
Mrs. G. d'A. Belin, President, Visiting Nurse Association, Scranton.
Mrs. E. U. Buckman, President, Visiting Nurse Association, Wilkes-Barre.
Mrs. J. M. Cameron, Board Member, Visiting Nurse Association, Harrisburg.
Miss Mary Cameron, President, Visiting Nurse Association, Harrisburg.
Mrs. Meade Detweiler, Jr., Board Member, Visiting Nurse Association, Harrisburg.
Mrs. Sanderson Detweiler, Board Member, Visiting Nurse Association, Lancaster.
Mrs. Charles Dorrance, Board Member, Visiting Nurse Association, Scranton.
Miss Dora Earle, Recording Secretary, Visiting Nurse Society, Philadelphia.
Mrs. J. W. Follin, Board Member, Neighborhood League, Wayne.
Mrs. Howard Freeze, Board Member, Visiting Nurse Association, Reading.
Mrs. Mortimer B. Fuller, Board Member, Visiting Nurse Association, Scranton.
Mrs. William O. Hickok, 4th, Board Member, Visiting Nurse Association, Harrisburg.
Miss Anna Huber, President, Visiting Nurse Association, York.
Mrs. Lesley McCreath, Chairman, Committee, Visiting Nurse Association, Harrisburg.
Mrs. Samuel Miller, President, Visiting Nurse Association, Lancaster.
Mrs. Garnett Pendleton, Recording Secretary, Red Cross & Health Service, Chester.
Mrs. C. E. Phreaner, President, Visiting Nurse Association, Hanover.
Miss Alice Scott, Treasurer, Visiting Nurse Society, Philadelphia.
Mrs. S. R. Slaymaker, Chairman, Nursing Committee, Visiting Nurse Association, Lancaster.
Mrs. Robert Tullar, President, Visiting Nurse Association, Lansdowne.

RHODE ISLAND

Mrs. Gammell Cross, Chairman, Nursing Committee, District Nursing Association, Providence.
Mrs. Frank E. Weeden, Chairman, American Red Cross, Jamestown.

TENNESSEE

Mrs. Arch Trawick, Member, State Department of Health, Nashville.

UTAH

Mrs. Isabelle Murphy, Board Member, Visiting Nurse Association, Salt Lake City.

VIRGINIA

Mrs. Henry M. Cowardin, Board Member, Instructive Visiting Nurse Society, Richmond.
Mrs. S. P. Duke, Chairman, Nursing Committee, Harrisburg.
Mrs. Herbert Mann, President, Instructive Visiting Nurse Society, Richmond.
Mrs. William Noland, Board Member, Instructive Visiting Nurse Society, Richmond.
Mrs. Olney H. Powers, Board Member, Stafford Co. Public Health Association, Quantico.

WISCONSIN

Mrs. H. P. Buck, President, Visiting Nurse Association, Neenah.
Mrs. L. Charles, Board Member, Visiting Nurse Association, Neenah.
Mrs. Kenneth Dawson, Board Member, Visiting Nurse Association, Neenah.
Mrs. A. C. Gilbert, Vice Chairman, Committee, Visiting Nurse Association, Neenah.
Mrs. D. L. Kimberly, Treasurer, Visiting Nurse Association, Neenah.
Dr. Dorothy Mendenhall, Chairman, Visiting Nurse Association, Madison.
Mrs. Donald Shepard, Board Member, Visiting Nurse Association, Neenah.

After thirteen years of service, Miss Grace Abbott has resigned as chief of the Children's Bureau in the Department of Labor to assume the position of Professor of Public Welfare in the School of Social Service Administration of the University of Chicago. In acknowledging her resignation, President Roosevelt writes:

"It is with great regret that I accept your resignation as chief of the Children's Bureau of the United States Department of Labor. You have filled that post with distinction and ability for thirteen years and have rendered service of inestimable value to the children and mothers and fathers of the country, as well as to Federal and State governments.

"In expressing my appreciation of the constructive policies of permanent value which you inaugurated and your exceptional ability as a far-sighted administrator I am also voicing that of the boys and girls and men and women all over the country who reaped their rich harvests."

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Approximately 50 radio stations throughout the United States and Canada have formed the broadcasting "chain" recently organized by the International Society for Crippled Children. These stations are participating in the program to broadcast material from the weekly bulletins issued by the Society dealing with the prevention and care of crippled children.

✣

Michigan has recently organized a State Organization for Public Health Nursing with the following officers:

President—Miss Melinka Herc, Detroit
Vice-President—Miss Winifred Golley, Charlevoix
Secretary—Miss Hazel Herringshaw, Calumet
Treasurer—Miss Bosse Randle, Grand Rapids
Sustaining Members—Mrs. James K. Watkins, Detroit; Mrs. M. J. Sherwood
Nurse Members—Miss Emilie Sargent, Detroit; Miss Grace Ross, Detroit
Lay Section:
Chairman—Mrs. L. B. Ruggles, Munising
Vice-Chairman—Mrs. Grace D. Robertson, Saginaw
Secretary—Mrs. I. A. Waddell, Detroit

The State of New Hampshire has recently organized the New Hampshire Women's Maternity Committee with the following objectives:

1. To promote measures which will make adequate maternity care universally available in New Hampshire.
2. To stimulate interest in local and state maternity programs.
3. To assist in teaching the public the importance of adequate maternity care and to help secure that care by working with the existing agencies for all expectant mothers.
4. To plan for a biennial meeting to be held with the Director of the Maternity Division of the State Board of Health and supervisors of other public health agencies doing maternity work.

EXCERPTS FROM A.P.H.A. PROGRAM, PASADENA, SEPTEMBER 3-6

Monday, September 3

Public Health Nursing Section Luncheon.
Speaker—Osgood Hardy, Director, Department of History and Government, Occidental College, Los Angeles—"Why Californians belong to the United States"
Health Officers' Section. "Trends in Public Health Nursing"—Pearl McIver, Nurse Consultant, U.S.P.H.S.
Joint Meeting of Public Health Nursing Section and American Social Hygiene Association

Wednesday, September 5

Public Health Nursing Section
Report of Committee to Study Nursing Services in State Health Department in cooperation with the N.O.P.H.N.
"Medical Advisory Committees for Public Health Nursing Services"—Florence C. Johnson, Director, Santa Barbara Visiting Nurse Association

Thursday, September 6

Public Health Nursing Section
Panel Discussion: "What Qualities Make for Success in a Public Health Nurse"—Dr. C.-E. A. Winslow, Chairman.

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The supervisory staff of the Bureau of Public Health Nursing, Health Department, City of New York, gave a luncheon at the Hotel Bossert in Brooklyn on Saturday, May 26, for Miss Amelia Grant in honor of her election as President of the N.O.P.H.N. The

superintendent of each of the five boroughs expressed the appreciation of her staff for the progress which has been made in public health nursing in the Health Department under Miss Grant's leadership. They congratulated the N.O.P.H.N. on securing Miss Grant as President and paid tribute to her by presenting her with a beautiful Sheffield silver tray. Miss Grant responded most feelingly, acknowledging her sincere pride in the loyalty of the staff and in its accomplishments.

The N.O.P.H.N. was represented by Miss Alma Haupt, who thanked the Health Department for sharing Miss Grant with the National Organization.

Directors of local health agencies in New York were guests of honor and said they looked forward to a continuous development in public health nursing throughout the country under the Presidency of Miss Grant in the N.O.P.H.N.

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The Michigan Board of Registration of Nurses will hold an examination September 4th and 5th for graduate nurses, September 4th for trained attendants, at The Peter White Library, Marquette. All applications with fees must be on file in the office of the Board of Registration of Nurses, 200 Hollister Building, Lansing, not later than August 20th. Mrs. Ellen L. Stahlnecker, R.N., Secretary.

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RECENT APPOINTMENTS

Ruth Hansen, visiting nurse for the John Hancock Mutual Life Insurance Company in the Chicago area.

Theda Waterman, Instructor in Public Health and Supervisor of Clinics in the Cook County Hospital School of Nursing, Chicago.

Daisy Dean Urch, Educational Director for board of examiners of nurses for Minnesota.

Miriam Dailey, American Red Cross Nursing Field Representative in Virginia, West Virginia and Ohio.

Ella Pensinger, Educational Director of the Westchester County, N. Y., Board of Health Nursing Service.

Sarah Addison, Field Supervisor with the Georgia State Child Health Nursing Project.

Laura Draper, Director of the recently combined nursing services, the Minneapolis Visiting Nurse Association and the Minneapolis Infant Welfare Society.

DETROIT STUDIES ITS NURSING NEEDS*

That the city of Detroit is not adequately nursed at the present time nor can most of the community pay for adequate services are the conclusions drawn in a study recently completed by the Committee on Research of the Detroit Joint Council on Nursing. The study was based on house-to-house visits by a nurse to selected groups in the city representing various nationalities and different levels of economic income.

The study showed that the acute conditions, especially those needing surgical interference, received the most nursing care while the biggest lack was in communicable disease nursing.

The following table shows the relation between the actual situation and the indicated need:

THE NUMBER OF NURSING DAYS GIVEN AND INDICATED AND THE NUMBER OF NURSES OF EACH TYPE REQUIRED PER YEAR FOR ENTIRE POPULATION.

Type	Given		Indicated	
	No. of Days	No. of Nurses	No. of Days	No. of Nurses
Graduate	521,400	1,423.5	1,238,400	3,392.3
Practical	25,000	68.5	1,384,600	3,793.5
Hospital	921,400	2,524.5	1,168,900	3,193.8
Mental			151,900	416.3
Hourly	1,000	2.75	21,700	59.4
Visiting Nursing	63,800	100.6	128,300	409.9
Health Education	29,200	111.8	83,800	320.2
Total	1,536,800	4,168.1	2,793,000	7,791.9

*For a more complete report of this study see the *American Journal of Nursing* for August.